

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11776
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1811676
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince. Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest. Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Hillcrest. Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 2504. Colebrook. Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie May Adams		4. DATE OF DEATH Oct. 5. 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May. 19. 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Carl. P. Shank		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George N. Adams. 2104. Minn. ave S E.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure 48 hours 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.H.D. DUE TO (c) diabetes mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-19-1927 to 10-5-1959 that I last saw the deceased alive on 10-5-1959 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5731 23rd Parkway SE 10-5-59 DATE SIGNED ACTUAL SIGNATURE David S. Gordon M.D. PHYSICIAN'S NAME (Type) DAVID S. GORDON, M.D. 21, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.8.1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar. Hill		22d. LOCATION (City, town, or county) (State) Suitland. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral. Home		24a. REC'D BY REGISTRAR DATE OCT 8 '59	
ADDRESS 300.4th. St. N E.		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11677

Reg. Dist. No.

11777

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u>		c. LENGTH OF STAY IN TB <u>9 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6309-E street</u>				d. STREET ADDRESS <u>6309-E Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Norman E</u> Middle <u>Andre</u> Last <u>Andre</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>		9. AGE (in years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Andre</u>				14. MOTHER'S MAIDEN NAME <u>Louise Grimes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-03-8554</u>		17. INFORMANT <u>Ego E Varnell, same as #2</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shirland md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>517 11th St SE</u>		24a. REC'D BY REGISTRAR <u>OCT 5 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur A. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

11710

CERTIFICATE OF DEATH

11678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Barnett</u> Last <u>GenDel</u>		4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/17/59</u>
9. AGE (In years last birthday) yrs. <u>13</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>James Barnett</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Jean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>Barbara Jean Mother Address same</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia</u> <u>500x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Acute tracheobronchitis</u> DUE TO (c) <u>Dehydration</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 28</u> , 19 <u>59</u> , to <u>Oct. 30</u> , 19 <u>59</u> , that I last saw the deceased alive <u>October 30</u> , 19 <u>59</u> , and that death occurred at <u>4:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Perkins</u>		ADDRESS (Street, city or town, state) <u>5301 Hault St., Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. John Perkins, M.D.</u>		DATE SIGNED <u>10/31/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-2-1959</u>	<u>Moses Cemetery</u>	<u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keaseth</u>		ADDRESS <u>108 Wash. St., Annapolis</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 4 '59</u>		<u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

11110



11110



11110



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11778

CERTIFICATE OF DEATH

11679

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George 4718 Shadyside Avenue MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park				c. LENGTH OF STAY IN 1b 9 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4718 Shadyside Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle Grace Last BEHAN				4. DATE OF DEATH Month Oct. Day 22 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1882	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77		IF UNDER 24 HRS. Days 77 Hours 77 Min. 77			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Louise M. White, 4718 Shadyside Ave., Wash., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Rime Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Sensitivity							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ac. Cholecystitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 18, 1959 to Oct. 22, 1959 , that I last saw the deceased alive on Oct. 21, 1959 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard Katzen M.D. 3550 M. N. N. Ave. S.E.				DATE SIGNED 10-22-59			
PHYSICIAN'S NAME (Type) BERNARD KATZEN M.D.				Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 24, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Richmond, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Maryland,				24a. REC'D BY REGISTRAR OCT 27 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		35		Male		White	
Place of Birth		Date of Birth		Date of Death		Cause of Death	
New York City		Jan 1, 1900		Jan 15, 1935		Heart Disease	
Address		City		County		State	
123 Main St		Boston		Suffolk		Massachusetts	
Occupation		Education		Marital Status		Previous Illnesses	
Teacher		High School		Married		None	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date		Time		Place		Remarks	
Jan 15, 1935		10:00 AM		Home		None	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11680

11779

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCOKKEK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS ROUTE 1 BOX 261		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle --- Last BISKEY				4. DATE OF DEATH Month OCTOBER Day 18 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 6, 1884	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---		IF UNDER 24 HRS. Hours --- Min. ---			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) ORSA, SWEDEN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PER PERSON				14. MOTHER'S MAIDEN NAME UNKNOWN KARIN BRAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NA		INFORMANT Address SON, FRANKLIN M BISKEY M/SGT SAME AS SEC 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) TERMINAL CARCINOMATOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 MINS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 OCTOBER , 1959, to 18 OCTOBER , 1959, that I last saw the deceased alive on 18 OCTOBER , 1959, and that death occurred at 11:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSPITAL ANDREWS 18 OCTOBER 1959							
ACTUAL SIGNATURE Jay H Poppel				M.D. USAF HOSPITAL ANDREWS			
PHYSICIAN'S NAME (Type) JAY H POPPEL CAPT USAF MC				USAF HOSPITAL ANDREWS, ANDREWS AFB, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 24 1959		22c. NAME OF CEMETERY OR CREMATORY BAPTIST CHURCH CEMETERY STAMFORD MINN.		22d. LOCATION (City, town, or county) (State) Braham Minnesota	
23. FUNERAL DIRECTOR'S SIGNATURE Rivaldi Funeral Home, 816 H St. N.E., Wash. 2, DC.				24a. REC'D BY REGISTRAR OCT 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Haus	

CERTIFICATE OF DEATH

11719

11080

Blank certificate form with horizontal lines for text entry.

CERTIFICATE OF DEATH

Reg. Dist. No. 11681

11711

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Xeland Memorial Hosp.</u>				d. STREET ADDRESS <u>1 R F. D. #2</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Bitting</u>				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-1871</u>	
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>		IF UNDER 24 HRS. Hours <u>8</u> Min. <u>8</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (Tobacco) Own Farm</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>A. S. A.</u>							
13. FATHER'S NAME <u>Israel Bitting</u>				14. MOTHER'S MAIDEN NAME <u>Anna Roup</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Hosp. records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Undetermined</u> (c) <u>Undetermined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hr.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , to <u>Oct 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>59</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u>			
DATE SIGNED <u>10-31-59</u>							
PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick S. Thomas</u>				ADDRESS <u>Upper Marlboro Md</u>		24a. REC'D BY REGISTRAR <u>NOV 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frederick S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11682

11712

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle J Last Blythe Jr		4. DATE OF DEATH Month Oct. Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9 Nov 1918
9. AGE (In years last birthday) 40 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Line TWA	11. BIRTHPLACE (State or foreign country) Virginia
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Line TWA		10b. KIND OF BUSINESS OR INDUSTRY Pilot	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Sam Blythe		14. MOTHER'S MAIDEN NAME Annie Dunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW 11	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Portal cirrhosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/24 , 19 59 , to Oct 17 , 19 59 , that I last saw the deceased alive on Oct/ 16 , 19 59 , and that death occurred at 4:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Hans Wodak, M.D.		ADDRESS (Street, city or town, state) 30-C Bridge Rd, GREENBELT, MD 10/17/59	
PHYSICIAN'S NAME (Type) 30 c Ridge Road, Greenbelt, Md.		DATE SIGNED 10/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 20, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE J. Gasch's Sons		ADDRESS Hyattsville, Md	
24a. REC'D BY REGISTRAR OCT 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

1002

DEPARTMENT OF HEALTH

1002

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11780
CERTIFICATE OF DEATH

11683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b 45 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mitchellville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle -- Last Bottner				4. DATE OF DEATH Month Oct. Day 9, Year 19 59.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 19, 1871	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Bavaria		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Bottner				14. MOTHER'S MAIDEN NAME Kresenia Stechle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT		Address Mr. Joseph Bottner- Mitchellville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conjunctive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Nephrosis						INTERVAL BETWEEN ONSET AND DEATH One month 10 pm 2 pm	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio-Vascular Renal Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 2, 1959 , to Oct 9, 1959 , that I last saw the deceased alive on Oct. 9, 1959 , and that death occurred at 8:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James G. Sasscer M.D. Upper Marlboro, Md. 10/9/59:							
ACTUAL SIGNATURE James G. Sasscer		PHYSICIAN'S NAME (Type) James G. Sasscer, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md				24a. REC'D BY REGISTRAR DATE OCT 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DEATH

11780

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Signature of informant: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11713

11684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE RAYMOND BOWLES		4. DATE OF DEATH Month Day Year October 2nd, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14th, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Prince Georges County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Bowles		14. MOTHER'S MAIDEN NAME Katherine (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) WW 1 WW 1		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Thomas F. Bowles, 5209 Logan St. Suitland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardio-vascular renal disease (c) 442X DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. T. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 3rd, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 6th, 1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Rd., Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517--11th St. S.E., Wash. D.C.		24a. REC'D BY REGISTRAR DATE OCT 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Krasa			

1 3 M 077 I 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 11714 11685 11714 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>1 Hour</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges general Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward Brooks</u>				4. DATE OF DEATH <u>Oct 31 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General labor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Edward Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Cassey Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War</u>				16. SOCIAL SECURITY NO. <u>705-07-7555</u>			
17. INFORMANT <u>Gertrude Matthew</u> Address <u>503-103 Laurel</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Pulmonary neoplasm</u> DUE TO (c) <u>Cardiac insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163x</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/5 1959</u> to <u>10/30 1959</u> , that I last saw the deceased alive on <u>10/30 1959</u> , and that death occurred at <u>1034 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Weaver</u> M.D.				ADDRESS (Street, city or town, state) <u>320 Montgomery St. Laurel Md.</u> DATE SIGNED <u>10/31/59</u>			
PHYSICIAN'S NAME (Type) <u>Frank T. Weaver</u>				Montgomery St. Laurel Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u> ADDRESS <u>1200 Snowden Place</u>				24a. REC'D BY REGISTRAR <u>NOV 5 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

Form 100-100

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

4.12

11781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 713 Maple Avenue		e. STREET ADDRESS 713 Maple Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Chancellor Brooks		4. DATE OF DEATH Month Day Year October 26, 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Public utilities	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-07-9185	
17. INFORMANT Bernard C. Brooks		Address Bowie, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of large bowel DUE TO (c) 12 mos			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct 22, 1959 to Oct 26, 1959 , that I last saw the deceased alive on Oct 26, 1959 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Henry C. Wise Jr.		ADDRESS (Street, city or town, state) 149 9th St Bowie Md	
PHYSICIAN'S NAME (Type) Henry A. Wise, Jr.		DATE SIGNED 10/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/59	22c. NAME OF CEMETERY OR CREMATORY Church of the Ascension	22d. LOCATION (City, town, or county) (State) Bowie, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Chas E. Edwards		24a. REC'D BY REGISTRAR DATE OCT 30 '59	
ADDRESS 30 H Street, N.E.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 100

PLACE OF DEATH		MARRIAGE	
HOSPITAL		MARRIED	
DATE OF DEATH		DATE OF MARRIAGE	
10/10/1918		10/10/1918	
TIME OF DEATH		TIME OF MARRIAGE	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
10/10/1918		10/10/1918	
TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM	
PLACE OF DEATH		PLACE OF DEATH	
HOSPITAL		HOSPITAL	
DATE OF DEATH		DATE OF DEATH	
10/10/1918		10/10/1918	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
10/10/1918		10/10/1918	
TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM	
PLACE OF DEATH		PLACE OF DEATH	
HOSPITAL		HOSPITAL	
DATE OF DEATH		DATE OF DEATH	
10/10/1918		10/10/1918	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
10/10/1918		10/10/1918	
TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM	

112 10/10/1918

30 H Street, N.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11687

11715

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 5028 Edgewood Rd	
3. NAME OF DECEASED (Type or print) First Ida Middle M Last Buchanan		4. DATE OF DEATH Month Oct. Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 14, 1923
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hubert Haywood		14. MOTHER'S MAIDEN NAME Tommye Bradford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) Metastatic Carcinoma of Lungs 162.1 DUE TO A Terminal Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) Primary Carcinoma of Left Lung INTERVAL BETWEEN ONSET AND DEATH 24 Months 24 hrs 9 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1959 to Oct 10, 1959 that I lost saw the deceased alive on Batcher 10, 1959 , and that death occurred at 2:30P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1746 K St. N.W. Wash - D.C. DATE SIGNED Oct 1959			
ACTUAL SIGNATURE George H. McFair		PHYSICIAN'S NAME (Type) George H. McLain, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR OCT 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Upper Marlboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Southern Maryland Medical Center</u>				d. STREET ADDRESS <u>Route 218 AA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KEVIN</u> Middle <u>DWAYNE</u> Last <u>BUTLER</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>BLK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 22, 1959</u>		9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u> Hours <u>3</u> Min. <u>—</u>	IF UNDER 24 HRS. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Butler Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beatrice Savoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		INFORMANT Address <u>JAMES H. Butler Jr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>7th month gestation</u> DUE TO (c) <u>10 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Andros</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 22, 1959</u> to <u>OCT 31, 1959</u> , that I last saw the deceased alive on <u>OCT 31, 1959</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred R. Lapin</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Clinton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHNSON-JENNINS</u>				ADDRESS <u>4804 GA. AVE</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>			

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

11689

11716

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Freda Middle Calvin Last Calvin		4. DATE OF DEATH Month October Day 12 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 June 1918
9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. gov	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Lee Smyer		14. MOTHER'S MAIDEN NAME Cora Barringer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. John E. Calvin Address St. Chone	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of aneurysm of the circle of Willis. (c) Cerebral			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REFERRED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/6/59 to 10/12/59 , that I last saw the deceased alive on 10/12/59 , and that death occurred at 2:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John Kehoe		ADDRESS (Street, city or town, state) 6300 Riverdale Rd - E. Riverdale Md	
PHYSICIAN'S NAME (Type) Dr. John Kehoe, M.D.		DATE SIGNED OCT 15 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Oct/14/59	22c. NAME OF CEMETERY OR CREMATORY Claremont Cemetery	22d. LOCATION (City, town, or county) (State) Claremont Md
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24a. REC'D BY REGISTRAR Arthur S. Thomas	
ADDRESS 300-4th St. N.E.		DATE OCT 15 '59	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

14348

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Valerie Chase		4. DATE OF DEATH Oct. 8 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) U.S.A.
13. FATHER'S NAME Eugene Chase		14. MOTHER'S MAIDEN NAME Arlene Cash	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Informant Address Mother Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, Neo-natal death 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 13 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 24, 1959 to Oct. 8, 1959 , that I last saw the deceased alive on Oct. 8, 1959 and that death occurred at 7:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		DATE SIGNED 12/28/59	
PHYSICIAN'S NAME (Type) John W. Perkins		ADDRESS (Street, city or town, state) 534 Hamilton St., Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George Sanitary		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Perkins		24a. REC'D BY REGISTRAR JAN 13 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G250 10-26-59 et
CERTIFICATE OF DEATH

11690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 11717 Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 23 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle C. K. Last Clark		4. DATE OF DEATH Month Oct. Day 17 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/85
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James Kenney		14. MOTHER'S MAIDEN NAME Ida Louise Preston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Informant Address Alice Harmon Daughter 5432 Spring Rd. Sunny	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Diabetic Acidosis DUE TO (b) Chronic Nephrosis DUE TO (c) Cong. Heart Failure		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/16 , 19 59 , to 10/17 , 19 59 that I last saw the deceased alive on 10/17 , 19 59 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hand Wodak		ADDRESS (Street, city or town, state) 30 C Prince Georges Rd, Greenbelt, Md DATE SIGNED 10-18-59	
PHYSICIAN'S NAME (Type) Dr. Hand Wodak, M.D.		Greenbelt, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/59	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE OCT 22 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11783 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11691

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Langley Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear of 1206 Lebanon Street			d. STREET ADDRESS 1206 Lebanon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Emmaverne Clark			4. DATE OF DEATH Month Day Year October 8 19 59		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-13	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Frank G. Leonard			14. MOTHER'S MAIDEN NAME Mary E., White		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-26-5978		17. INFORMANT Hardy Leonard; Address 8216 18th Ave. Adelphi, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of chest (c) DUE TO (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by a gun held in the hand of another person.			
20c. TIME OF INJURY Month, Day, Year 7.15 a. m. 10-8-1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking area	
20f. (City or town) Langley Park, Pr. Geo.		20g. (County) Md.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED October 8, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
22d. LOCATION (City, town, or county) Bladensburg, Md.		22e. (State) Md.		22f. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home. Washington D.C.			24a. REC'D BY REGISTRAR DATE OCT 13 1959		
24b. REGISTRAR'S SIGNATURE Arthur E. Hanna			24c. (State) Md.		

11801
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John T. Johnson		Male		45		10-10-1950		Baltimore, Md.	
Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
Clerk		Heart Disease		Natural		10:30 AM		[Signature]	
Residence		Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital	
1234 Main St.		1-1-1905		Baltimore, Md.		10-5-1950		10-10-1950	
Marital Status		Previous Illnesses		Previous Operations		Previous Injuries		Previous Habits	
Married		Hypertension		None		None		Smoker	
Family History		Social History		Occupational History		Travel History		Military Service	
None		None		None		None		None	
Physician's Name		Physician's Address		Physician's Phone		Physician's Signature		Physician's Title	
Dr. J. K. Smith		123 Main St.		123-4567		[Signature]		M.D.	
Hospital Name		Hospital Address		Hospital Phone		Hospital Signature		Hospital Title	
St. Mary's Hospital		123 Main St.		123-4567		[Signature]		M.D.	
Coroner's Name		Coroner's Address		Coroner's Phone		Coroner's Signature		Coroner's Title	
Mr. J. K. Smith		123 Main St.		123-4567		[Signature]		M.D.	
Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Phone		Medical Examiner's Signature		Medical Examiner's Title	
Dr. J. K. Smith		123 Main St.		123-4567		[Signature]		M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11718 CERTIFICATE OF DEATH

Reg. Dist. No. 11692

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>16hrs 35min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Mayhew</u> Last <u>Cole</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mayhew</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Hillman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Elizabeth M. Cole, Daughter</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332 X DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u>Hyattsville Md.</u>	
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>33</u> , to <u>10-14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Deitz</u>		DATE SIGNED <u>10-14-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Aaron Deitz</u>		ADDRESS (Street, city or town, state) <u>Hyattsville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation 10/15/59</u>		22b. DATE THEREOF <u>10/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wellfleet</u>		22d. LOCATION (City, town, or county) (State) <u>Massachusetts</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 16 '59</u>	
ADDRESS <u>Hyattsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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STATE OF NEW YORK

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "and", "the", "of" are visible.]

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TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11719

CERTIFICATE OF DEATH

11693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 16 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pro Georges Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 4910 Powder Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gordon Middle C Last Collins		4. DATE OF DEATH Month Oct. Day 8 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-12-1888	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 7 Days 11 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY People		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Thomas P. Collins		14. MOTHER'S MAIDEN NAME Mary Linton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220 12 3850A		INFORMANT Address Anne Collins 4916 Harford Rd. College Pk., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure DUE TO (c) Advanced nephrosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3303 Perry St	
20f. (City or town) Mt Rainier Md.		20g. (County) Beltsville, Md.		20h. (State) Md.	
21. I certify that I attended the deceased from Sept. 15 , 19 59 , to Oct. 8 , 19 59 , that I last saw the deceased alive on Oct. 8 , 19 59 , and that death occurred at 7:30A , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3303 Perry St Mt Rainier Md 10/8/59 DATE SIGNED 203 Hagan ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) W. B. Hagan Mt Rainier Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/59		22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery	
22d. LOCATION (City, town, or county) Beltsville, Md.		22e. (State) Md.		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
24b. REGISTRAR'S SIGNATURE Collins		24c. (Signature) Collins			

CERTIFICATE OF DEATH

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11720

CERTIFICATE OF DEATH

Reg. Dist. No.

11695

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle Correll Last 		4. DATE OF DEATH Month Oct. Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/82
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Louis A. Smith		14. MOTHER'S MAIDEN NAME Mary E. Eilingsfeld	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 03 8486	
INFORMANT Eleanore Moyers daughter Address same		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS, ACUTE, MASSIVE Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/29 , 19 59 , to 10/5 , 19 59 that I last saw the deceased alive on October 5 , 19 59 , and that death occurred at 6:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 10/5/59	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU		MT RAINIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR Oct 13 59 DATE 	
24b. REGISTRAR'S SIGNATURE Arthur A. Thomas			

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CERTIFICATE OF DEATH

11697

WILLIAM R. ALLEN

WILLIAM R. ALLEN

WILLIAM R. ALLEN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11697

CERTIFICATE OF DEATH

Reg. Dist. No.

11696

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY KINGSTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE			c. LENGTH OF STAY IN 1b 4 YEARS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOME			d. STREET ADDRESS 165 FAIR STREET		
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last CULLEN			4. DATE OF DEATH Month 10 Day 26 Year 19 59		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 26, 1881		9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL TEACHER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KINGSTON, N. Y.
13. FATHER'S NAME SAMUEL THOMPSON			14. MOTHER'S MAIDEN NAME ? BALLARD		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT SACRED HEART HOME HYATTSVILLE, MARYLAND			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 6 , 19 56 , to 10-25 , 19 59 , that I last saw the deceased alive on 10-25 , 19 59 , and that death occurred at 12 45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 322 H ST. N.E. WASH. D.C. DATE SIGNED 10/26/59					
ACTUAL SIGNATURE Thomas F. Collins M.D. 322 H ST. N.E. WASH. D.C.					
PHYSICIAN'S NAME (Type) THOMAS F. COLLINS 322 H St. N.E. Wash. D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-59	22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		22d. LOCATION (City, town, or county) (State) KINGSTON N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Collins ADDRESS WASH. D. C.			24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS 3821 14TH. ST. N.W.			DATE OCT 28 59		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11697

11784

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland, Maryland</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Suitland, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4612- Porter Ave., S.E.</u>				d. STREET ADDRESS <u>4612- Porter Ave., S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>DETLEFS</u> Last <u>DETLEFS</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>6th.</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 28- 1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Murken.</u>				14. MOTHER'S MAIDEN NAME <u>Louise Walsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Louis F. Detlefs</u> Address <u>Same as # 2.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Myeloma</u> DUE TO (c) <u>1 yr</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Oct 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>59</u> , and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Ruedy</u> M.D. <u>2904 N. Highland St.</u> DATE SIGNED <u>10-6-59</u>							
PHYSICIAN'S NAME (Type) <u>JOHN J. RUEDY</u>				<u>Walton L. R. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1661- G. Adams</u> <u>Semmons Bros.</u> Washington 20, D.C.				24a. REC'D BY REGISTRAR DATE <u>OCT 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11698

Reg. Dist. No.

11721

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 28 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs		1556-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 2403 Dennis Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael Dabosh				4. DATE OF DEATH Month October Day 8 Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1925-2-22-04		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Dabosh				14. MOTHER'S MAIDEN NAME Susan Kral			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 175-16-8534		17. INFORMANT Guy Bella; 13207 Kara Lane, Silver Springs, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Massive laceration of liver and crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with a telephone pole,					
20c. TIME OF INJURY Month, Day, Year 12-45 Hour 10-7- 19 59		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Laurel, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/12/59		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>				24a. REC'D BY REGISTRAR Raymond A. Ziska		24b. REGISTRAR'S SIGNATURE <i>October 9, 1959</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING 78
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Silver Springs		Male		20	
Place of Birth		Date of Birth		Date of Death	
Silver Springs		1900		1920	
Cause of Death		Manner of Death		Occupation	
Heart Disease		Natural		Farmer	
Medical History		Previous Illnesses		Drugs Taken	
None		None		None	
Signature of Examiner		Signature of Coroner		Signature of Physician	
Michael J. Lynch		John J. Lynch		John J. Lynch	
Date		Time		Place	
1920		10:00 AM		Silver Springs	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
11722
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG251 11-13-59 et
CERTIFICATE OF DEATH

Reg. Dist. No.

11699

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 24 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle H Last Dodge				4. DATE OF DEATH Month October Day 31 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/1/71/	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer, Retired		10b. KIND OF BUSINESS OR INDUSTRY Judd & Detweiler		11. BIRTHPLACE (State or foreign country) Bangor, Maine		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas H. Dodge				14. MOTHER'S MAIDEN NAME Henrietta Thrush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-12-8281			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) JAUNDICE DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Biliary obstruction DUE TO (c) CARCINOMA of head of PANCREAS				INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 56 , to Oct 31 , 19 59 , that I last saw the deceased alive on October 31 , 19 59 , and that death occurred at 7:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sam A. Smith				ADDRESS (Street, city or town, state) 3408 Rhode Island Ave. Mt. Rainier, Md.			
PHYSICIAN'S NAME (Type) Dr. Levitsky				DATE SIGNED 11/1/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home Inc.				24a. REC'D BY REGISTRAR NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Howard	

STATE OF ALABAMA - BIRMINGHAM

1922

IN SENATE
JANUARY 10, 1922
REPORT
OF THE
COMMISSIONER OF THE
BUREAU OF
PRISONS
AND
REFORMATORY
SYSTEM
FOR THE
YEAR
1921
BY
J. M. HARRIS
COMMISSIONER
BIRMINGHAM, ALA.
1922

11785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u>				c. LENGTH OF STAY IN 1b <u>50YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>504 68TH ST.</u>				d. STREET ADDRESS <u>504 68TH ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUKA ANN DONN</u>				4. DATE OF DEATH Month Day Year <u>OCT. 7TH 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 24-1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ROSS W. MORRISON</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE WARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MAYNARD DONN</u> Address <u>5119 61 PLACE CRT. HTS. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> (c) <u>Diabetes mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 WK</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1959</u> to <u>Oct. 7, 1959</u> , that I last saw the deceased alive on <u>Oct. 6, 1959</u> , and that death occurred at <u>3:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Max M. Herzberg</u>				DATE SIGNED <u>7016-Prep St. Seat Pleasant, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W.W. Chamber Co. 517 11th St. S.E.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>19 159</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Shutland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co. 517 11th St. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1954

100

11723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb D.O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 6820 Pineway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nathan Middle Lincoln Last Drake				4. DATE OF DEATH Month October Day 13 , Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-98		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief of Dept. of Chemistry, U. of Md.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frederick L. Drake			14. MOTHER'S MAIDEN NAME Ada Hale				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) P.		16. SOCIAL SECURITY NO. 578 48 0191		17. INFORMANT Dorothy Weston; 2624 N.E. 25th St., Ft. Lauderdale, Florida			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REINTERMENT Cremation				22b. DATE THEREOF Oct 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory	
22d. LOCATION (City, town, or county) Colmar Manor, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BAYLOR 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		TIME OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
SIGNATURE OF MEDICAL EXAMINER [REDACTED]		SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF JURY [REDACTED]	
CERTIFICATE OF DEATH [REDACTED]		CERTIFICATE OF DEATH [REDACTED]		CERTIFICATE OF DEATH [REDACTED]	

CHIEF OF BUREAU

11724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges' General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maude Middle --- Last Duvall			4. DATE OF DEATH Month October Day 23 Year 1959.				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1873		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 6 Days 20 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Franklin Duvall				14. MOTHER'S MAIDEN NAME Susan Jane Sasscer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---		INFORMANT Catherine Burroughs - Upper Marlboro, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 6 months 20 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 28 , 1959, to Oct 23 , 1959, that I last saw the deceased alive on Oct 22 , 1959, and that death occurred at 6:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Sasscer M.D.				ADDRESS (Street, city or town, state) Upper Marlboro, Md - 10-23-59			
PHYSICIAN'S NAME (Type) James G. Sasscer, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/59		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Croom, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Marlboro, Md.				24a. REC'D BY REGISTRAR OCT 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
IN SENATE
January 10, 1907.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1906.
ALBANY:
J. B. LEECH, STATE PRINTER.
1907.

NEW YORK
JAN 10 1907
RECEIVED
STATE OF NEW YORK
JAN 10 1907
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11703

11786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5087 Dunlap Street</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> d. STREET ADDRESS <u>5087 Dunlap Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Charles Herr Enterline</u> First Middle Last				4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1959</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 19, 1911</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>John's Webster</u>				11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Enterline</u>						14. MOTHER'S MAIDEN NAME <u>Elta Bitler</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Charles Enterline, same as #2</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>James I. Boyd</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct 9, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct 12-59</u>				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill</u>				22d. LOCATION (City, town, or county) <u>Switzland Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>						ADDRESS <u>1661 - good Hope Rd SE</u>						24a. REC'D BY REGISTRAR <u>Oct 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park				c. LENGTH OF STAY IN 1b transient			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear of 1206 Lebanon Street				e. STREET ADDRESS 5410 Shadyside Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Estil Middle Clay Last Eskridge				4. DATE OF DEATH Month October Day 8 Year 1959			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-15	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Egg Salesman				10b. KIND OF BUSINESS OR INDUSTRY Eggs		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Shelby Eskridge				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2		17. INFORMANT Address Grace Eskridge; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Gunshot wound of head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head.					
20c. TIME OF INJURY Month, Day, Year 7.15 P.M. 10-8-1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking area		20f. (City or town) Langley Park, Pr. Geo Md. (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 8, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-59		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		22d. LOCATION (City, town, or county) Arlington, Virginia (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., Inc. ADDRESS 517-11 St. A.E.				24a. REC'D BY REGISTRAR OCT 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Fraser	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11705

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Max Francis Farrar		4. DATE OF DEATH Month 10-10- Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-10
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Property and supply officer. U.S. Gun Fact.		10b. KIND OF BUSINESS OR INDUSTRY California	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Pigg		14. MOTHER'S MAIDEN NAME Dessie Farrar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Clarisse Farrar; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest and fractured skull DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile which turned over several times.	
20c. TIME OF INJURY Month, Day, Year Hour 6.05 p. m. 10-10-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Beltsville (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 12, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10/13/59	22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory	22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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220 J. S. F. de Winter

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11726

CERTIFICATE OF DEATH

Reg. Dist. No.

11706

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Branchville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>No fixed address</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>W.</u> Last <u>Fogle</u>				4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1913</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Harvey Fogle</u>				14. MOTHER'S MAIDEN NAME <u>Annie B Shabb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>WW 11</u>			
17. INFORMANT <u>Mrs. Margaret Ware (Sister)</u> Address <u>Hospital Record 75001 Apache St, Branchville Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thromboses</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 7, 1959</u> , to <u>Oct 8, 1959</u> , that I last saw the deceased alive on <u>Oct 8, 1959</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>10-8-59</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>				<u>Riverdale Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Cemetery Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Online & Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

11758

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15, 1900</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 1, 1925</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10, 1945</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>	
<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>16. SIGNATURE OF DECEASED <i>John Doe</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11727 **CERTIFICATE OF DEATH**

Reg. Dist. No.

11707

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 46 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 25	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 6207 Beale Ct.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frederick Middle K Last Ford		4. DATE OF DEATH Month Oct Day 25 Year 19 59					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1905	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sub Station Operator		10b. KIND OF BUSINESS OR INDUSTRY P E P Company		11. BIRTHPLACE (State or foreign country) Annapolis Md.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Frederick K Ford				14. MOTHER'S MAIDEN NAME Sara Rebecca Shafer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Laura M Ford Riverdale Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage 540.1 DUE TO Perforating duodenal ulcer 16 days Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary & Splenic Infarcts. Cholelithiasis							INTERVAL BETWEEN ONSET AND DEATH 16 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-5 , 19 55 , to 10-25 , 19 59 , that I last saw the deceased alive on Oct 25 , 19 59 , and that death occurred at 9 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Saul Schwartzback		ADDRESS (Street, city or town, state) DATE SIGNED 1726 Eye St., NW Wash, D.C. 10-26-59					
PHYSICIAN'S NAME (Type) Dr. Saul Schwartzback		Washington D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 28, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR OCT 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1352

100

11728

CERTIFICATE OF DEATH

Reg. Dist. No.

11708

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 33 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH Month October Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1959
9. AGE (In years last birthday) 33		10. IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min. 33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Fowler		14. MOTHER'S MAIDEN NAME Mary Louise Orr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Anoxia DUE TO prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prematurity (c) prematurity			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 13 , 19 59 , to Oct 13 , 19 59 that I last saw the deceased alive on Oct 13 , 19 59 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1840 Michigan Ave. NE DATE SIGNED 10-13-59			
ACTUAL SIGNATURE James E. Abell M.D.		PHYSICIAN'S NAME (Type) Dr. James E. Abell	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Oct 19 1959	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Administrator		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

11752

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CERTIFICATE OF DEATH

Reg. Dist. No.

11709

11788

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paint Branch Nursing Home</i>		d. STREET ADDRESS <i>160 Irving St Apt 20</i>	
3. NAME OF DECEASED (Type or print) <i>ARTHUR</i> First <i>WINNOCHE</i> Last <i>GARRETT</i>		4. DATE OF DEATH <i>OCTOBER 1 1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12-1872</i>
9. AGE (In years lost birthday) <i>87</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad-retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ta</i>	
11. BIRTHPLACE (State or foreign country) <i>Ta</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm Robt Wyatt Garrett</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Ellen Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Arthur L. Garrett Jr - son</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHIAL PNEUMONIA</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ARTERIOSCLEROSIS</i> DUE TO (c) <i>DIABETES MELLITUS</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i> <i>YEARS</i> <i>YEARS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 4, 1956</i> to <i>SEPT 30, 1959</i> , that I last saw the deceased alive on <i>SEPT 30, 1959</i> , and that death occurred at <i>10:22 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. Louis Mendel</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>4506 COLLEGE AVE 10/1/59</i>	
PHYSICIAN'S NAME (Type) <i>C. LOUIS MENDEL</i>		<i>COLLEGE PARK MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-3-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>College Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Southern Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 5 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Garrett</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
BOSTON
MAY 10 1918

<p>1. Name of deceased: <i>John J. Smith</i></p>	
<p>2. Age: <i>45</i></p>	
<p>3. Sex: <i>Male</i></p>	
<p>4. Date of death: <i>May 8, 1918</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart failure</i></p>	
<p>7. Signature of physician: <i>Dr. J. H. Brown</i></p>	
<p>8. Signature of registrar: <i>W. H. Jones</i></p>	
<p>9. Date of registration: <i>May 10, 1918</i></p>	
<p>10. Place of registration: <i>Boston</i></p>	

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 11 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11698

CERTIFICATE OF DEATH

11710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.		c. LENGTH OF STAY IN 1b 10 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.		d. STREET ADDRESS 4408 Beechwood Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4408 Beechwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) J. EARL GINGELL		4. DATE OF DEATH Month October Day 9 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 18, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 9 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Gas Station	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James D Gingell		14. MOTHER'S MAIDEN NAME Mary Jane Philias	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Loring E Gingell		Address Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Chr Myocard DUE TO (c) 6 yrs		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-2 , 19 59 , to 10/9 , 19 59 , that I last saw the deceased alive on 10/9 , 19 59 , and that death occurred at 5 C M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M B Steward		DATE SIGNED 314 Compton Ave Laurel Md 10/9/59	
PHYSICIAN'S NAME (Type) M B Steward		ADDRESS (Street, city or town, state) 314 Compton Ave Laurel Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 12, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Arthur H. Kraus	

11789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 2 Box 21</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM JOHN GLASS</u>				4. DATE OF DEATH Month Day Year <u>Oct. 26 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 17, 1903</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO</u>			
11. BIRTHPLACE (State or foreign country) <u>Phil. Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>—</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1927</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>EVELYN GLASS-DAUGHTER</u> Address <u>RT 2 Box 21 CLINTON, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE 20 MIN.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE WITH ANGINA PECTORIS</u> DUE TO (c) <u>1 1/2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE RT. HIP - DURATION 4 wks.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>NONE</u> 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>	
20f. (City or town) <u>NONE</u> (County) <u>NONE</u> (State) <u>NONE</u>							
21. I certify that I attended the deceased from <u>JUNE</u> 19 <u>59</u> , to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT. 24</u> , 19 <u>59</u> , and that death occurred at <u>5:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Branch Ave. Clinton Md.</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAYER JR.</u>				DATE SIGNED <u>10/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Clinton</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond J. Ryan</u> ADDRESS <u>1661 Good Hope Rd SE WASH DC</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 29 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11712

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>6701 Pr Geo. Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Thomas</u> Last <u>Gordon</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Eva. Ansie Raley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give no. or date of service) <u>Yes. No. 2</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs M Gordon</u>		Address <u>6701 Pr Geo Ave Takoma Park Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of head of pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Metastasis to liver</u> DUE TO (c) <u>1st Symptomatic pancreas</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7/20/59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/26</u> , 19 <u>59</u> , to <u>10/16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>59</u> , and that death occurred at <u>10:58</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>7030 Carroll Ave. Takoma Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		DATE SIGNED <u>10/16/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. Wash D.C.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13 Film G251 10-30-59 et

Reg. Dist. No.

11713

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 78 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 9031 Volta Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Graham Last Graham		4. DATE OF DEATH Month October Day 25 Year 19 59							
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-86	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72	IF UNDER 24 HRS. Days 72	Hours 72	Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY P.O. Clerk		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Joseph Graham				14. MOTHER'S MAIDEN NAME Adeline Blake					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT Theodore Wilson; same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (b) Osteomyelitis (c) Compound, comminuted fracture of right tibia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A pedestrian, struck by a hit and run.							
20c. TIME OF INJURY Hour 9:15 p. m. Month, Day, Year Aug. 7 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Landover		(County) Pr. Geo.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney		EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 25, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-29-59		22b. DATE THEREOF 10-29-59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON		22d. LOCATION (City, town, or county) ARLINGTON VA		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST SARVIS Co.				ADDRESS 1432 York St., N.W.		24a. REC'D BY REGISTRAR DATE OCT 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John T. Jones		Male		45		Jan 1, 1900	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Clerk		High School		Hypertension		None	
Date of Death		Time of Death		Place of Death		Physician	
Jan 15, 1945		10:30 AM		Home		J. H. Smith, M.D.	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11714

11730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 Day, 16 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 25 d. STREET ADDRESS 5304- 56th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Preston Middle Thomas Last Granados			4. DATE OF DEATH Month Oct. Day 29 Year 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1959	9. AGE (In years lost birthday) yrs. 0	IF UNDER 1 YEAR Months 0 Days 1 Hours 15 Min. 53		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Infant		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Rey Granados			14. MOTHER'S MAIDEN NAME Louise Cecelia Eichhorn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		INFORMANT Mother Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 750x Anencephaly DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Day 16 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 30-C Ridge Rd., Greenbelt, Md.			
20f. (City or town) Greenbelt		20g. (County) Prince George's		20h. (State) Md.			
21. I certify that I attended the deceased from October 28, 1959 to October 29, 1959 , that I last saw the deceased alive on October 28, 1959 , and that death occurred at 10:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stam Woodak		DATE SIGNED 30-C Ridge Rd., Greenbelt, Md. 10-29-59					
PHYSICIAN'S NAME (Type) Dr. Hans Wodak		30-C Ridge Rd., Greenbelt, Md., 10-29-59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			
22d. LOCATION (City, town, or county) Washington		22e. (State) D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.		ADDRESS 1300 - N St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR NOV 2 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kiana							

2077233XV5

11530

CERTIFICATE OF MARRIAGE

STATE OF NEW YORK

BEFORE ME, the undersigned authority, on this day personally appeared _____

known to me to be the person whose name is subscribed to the foregoing

instrument, and acknowledged to me that he executed the same for the

purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____

Notary Public

Witness my hand and seal of office this _____ day of _____

at _____ in the County of _____ State of New York.

[Signature]

Witness my hand and seal of office this _____ day of _____
at _____ in the County of _____ State of New York.

Notary Public

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11715

11731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beltsville Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Thomas</u> Last <u>Gross</u>		4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alexander Gross</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MARY Brewer</u>		Address <u>Beltsville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>59</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank J. McLean, Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10/27/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-31-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carver Park</u>		22d. LOCATION (City, town, or county) (State) <u>Murkb's Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington & Son</u> ADDRESS <u>461 N. 7th W.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

11731

<p>1. NAME OF DECEASED <i>John Jones</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>10-15-1890</i></p>	
<p>5. PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>6. OCCUPATION <i>Student</i></p>	
<p>7. MARITAL STATUS <i>Single</i></p>		<p>8. DATE OF DEATH <i>10-27-1935</i></p>	
<p>9. TIME OF DEATH <i>10:30 AM</i></p>		<p>10. PLACE OF DEATH <i>Johns Hopkins</i></p>	
<p>11. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>12. MEDICAL HISTORY <i>None</i></p>	
<p>13. SIGNATURE OF PHYSICIAN <i>Johns Hopkins</i></p>		<p>14. SIGNATURE OF REGISTRAR <i>Johns Hopkins</i></p>	
<p>15. SIGNATURE OF WITNESS <i>Johns Hopkins</i></p>		<p>16. SIGNATURE OF DECEASED <i>Johns Hopkins</i></p>	
<p>17. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>18. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>19. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>20. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>21. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>22. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>23. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>24. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>25. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>26. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>27. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>28. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>29. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>30. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>31. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>32. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>33. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>34. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>35. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>36. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>37. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>38. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>39. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>40. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>41. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>42. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>43. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>44. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>45. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>46. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>47. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>48. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>49. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>50. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>51. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>52. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>53. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>54. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>55. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>56. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>57. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>58. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>59. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>60. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>61. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>62. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>63. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>64. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>65. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>66. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>67. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>68. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>69. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>70. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>71. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>72. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>73. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>74. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>75. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>76. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>77. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>78. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>79. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>80. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>81. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>82. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>83. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>84. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>85. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>86. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>87. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>88. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>89. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>90. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>91. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>92. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>93. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>94. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>95. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>96. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>97. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>98. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	
<p>99. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>		<p>100. SIGNATURE OF DECEASED'S NEXT OF KIN <i>Johns Hopkins</i></p>	

RECEIVED
BALTIMORE
OCT 28 1935
DEPARTMENT OF HEALTH

11699

CERTIFICATE OF DEATH

11716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges' Co., MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MRS. BELL'S NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-59</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>40</u> Hours <u>15</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sol Haberman</u>		14. MOTHER'S MAIDEN NAME <u>Melba Livney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sol Haberman</u>		Address <u>112 Lee Ave., Takoma Park Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spina bifida = Hydrocephalus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease with failure</u> DUE TO (c) <u>-----</u>			INTERVAL BETWEEN ONSET AND DEATH <u>40 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 13, 1959</u> to <u>Oct. 11, 1959</u> , that I last saw the deceased alive on <u>Oct. 7, 1959</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mary K. L. Sartwell</u> , M.D.		ADDRESS (Street, city or town, state) <u>6811 RIGGS RD., Hyattsville, Md.</u>	
DATE SIGNED <u>10-11-59</u>			
PHYSICIAN'S NAME (Type) <u>MARY K. L. SARTWELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>10/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphtey</u>		ADDRESS <u>Bethesda, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVVVVV

11791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Geo Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Pri. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capital Hghts</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>36 Capital Hghts, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1004 Highway DC</i>		d. STREET ADDRESS <i>1004 Highway DC</i>	
3. NAME OF DECEASED (Type or print) <i>Francis Charles Hamm</i>		4. DATE OF DEATH Month <i>10</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 7 1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Fireman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Joseph Hamm</i>		14. MOTHER'S MAIDEN NAME <i>Madeline Rasan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Albertina Hamm - wife</i>		Address <i>1004 Highway DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>Emphysema pulmonum.</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>3-29-1958</i> to <i>10-4-1959</i> , that I last saw the deceased alive on <i>10-4-1959</i> , and that death occurred at <i>12:45 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <i>10/3/59</i>			
ACTUAL SIGNATURE <i>Peter Duus</i> M.D.		PHYSICIAN'S NAME (Type) <i>PETER DUUS</i> <i>Capital Heights Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>10-4-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Scranton Pa</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons Co</i>		ADDRESS <i>300-4th St NE Wash DC</i>	24a. REC'D BY REGISTRAR DATE <i>OCT 7 59</i>
		24b. REGISTRAR'S SIGNATURE <i>William S. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1191

REG. NO.

<p>1. Name of deceased (Print name and surname) _____</p>		<p>2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. Date of birth (Month, day, year) _____</p>		<p>4. Place of birth (City, State, Country) _____</p>	
<p>5. Date of death (Month, day, year) _____</p>		<p>6. Place of death (City, State, Country) _____</p>	
<p>7. Cause of death (Immediate cause) _____</p>		<p>8. Cause of death (Underlying cause) _____</p>	
<p>9. Date of funeral (Month, day, year) _____</p>		<p>10. Name of funeral home _____</p>	
<p>11. Signature of physician (Print name) _____</p>		<p>12. Signature of registrar (Print name) _____</p>	
<p>13. Signature of informant (Print name) _____</p>		<p>14. Signature of witness (Print name) _____</p>	

DECEASED

DECEASED

DECEASED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11718

11732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville--White House Motel	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS Route # 301	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			
3. NAME OF DECEASED (Type or print) WILLIAM First AUGUSTINE Middle XXXXXXXXXX Last HAMMER		4. DATE OF DEATH October 5th, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28th, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 5 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel Operator		10b. KIND OF BUSINESS OR INDUSTRY Motel	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Hammer		14. MOTHER'S MAIDEN NAME Catherine Terrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 117-12-0998	
17. INFORMANT Mrs. Margaret V. Hammer, Mitchellville, Md.		Address White House Motel	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Arterio-sclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED October 5th, 1959	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Raymond's Cemetery	22d. LOCATION (City, town, or county) (State) Bronx, New York
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. W. CHAMBERS CO., Riverdale, Maryland.		24a. REC'D BY REGISTRAR DATE OCT 9 '59	
		24b. REGISTRAR'S SIGNATURE Catherine P. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11732

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		James J. Boye, Jr.	
Date of Death		Oct. 2, 1952	
Place of Death		St. Raymond's Hospital, Baltimore, Maryland	
Age		38 years	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Hotel	
Usual Residence		New York	
Place of Birth		Catharine, Newell	
Cause of Death		Acute myocardial infarction	
Manner of Death		Natural	
Signature of Examiner		<i>[Signature]</i>	
Date of Certificate		October 5, 1952	

CERTIFICATE OF DEATH

Reg. Dist. No.

11719

11733

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Hawkins				4. DATE OF DEATH Month Day Year October 20 1959			
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Feb 1905	9. AGE (In years lost birthday) yrs. 54	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY D.C.		12. CITIZEN OF WHAT COUNTRY?		
11. BIRTHPLACE (State or foreign country)							
13. FATHER'S NAME Oscar Hawkins				14. MOTHER'S MAIDEN NAME Lottie Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Essential hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 20 mos. 3 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from October 19, 1959 to October 20, 1959 , that I last saw the deceased alive on October 19, 1959 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hans Wodak			DATE SIGNED 10-20-59				
PHYSICIAN'S NAME (Type) Dr. Hans Wodak, M.D.			ADDRESS (Street, city or town, state) 30-C Bridge Rd, Greenbelt, Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart			ADDRESS 30-H St. N.E.		24a. REC'D BY REGISTRAR OCT 22 '59		
					24b. REGISTRAR'S SIGNATURE Charles S. Harris		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

22

11734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Iceland Memorial</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			
f. STREET ADDRESS <u>1 1/2 09 Queensbury Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry Z.</u> Middle <u>Hayes</u> Last <u></u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/28/63</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Yard</u>			
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Nettie J. Hayes, wife</u>		Address <u>same as n0 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart Failure</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Pl. fell @ home</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>9/31</u> Mpnth. <u>1959</u> Day <u></u> Year <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Riverdale P.G. M.D.</u>	
21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>59</u> , to <u>10-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-6</u> , 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theo. Zagarra, M.D.</u>				ADDRESS (Street, city or town, state) <u>4404 Queensbury Rd Riverdale Md</u>			
DATE SIGNED <u>10/7/59</u>							
PHYSICIAN'S NAME (Type) <u>Theo. Zagarra, M.D.</u>				Riverdale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Cinbur & Kines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-CALTIMORE, 18



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11735

CERTIFICATE OF DEATH

11721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City d. STREET ADDRESS 3810 40th Pl. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Hamilton Haynes		4. DATE OF DEATH Month Day Year Oct 27 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 5 17	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY C. & O. Railroad	
11. BIRTHPLACE (State or foreign country) Alleghany County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hamilton Haynes		14. MOTHER'S MAIDEN NAME Emily Zeigler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Lillian Herck, Grand daughter		Address 3810, 40th Pl Cottage City Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and bronchiectasis 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis, right occipital lobe DUE TO (c) Hydrocephalus, cause undetermined			
INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of cecum with intestinal hemorrhage			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3101 ARUNDEL RD, MT. RAINIER, MD DATE SIGNED 10/27/59 ACTUAL SIGNATURE Irvin M. Grassgreen M.D. PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Alleghany Memorial Park		22d. LOCATION (City, town, or county) (State) Lowmoor Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE A. Lee Smith		ADDRESS Covington, Va.	
24a. REC'D BY REGISTRAR DATE NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kious	

CERTIFICATE OF DEATH

1935

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Signature of informant: _____

12. Date of registration: _____

13. Place of registration: _____

14. Registrar's name: _____

15. Registrar's address: _____

16. Registrar's telephone: _____

17. Registrar's signature: _____

18. Registrar's stamp: _____

19. Registrar's seal: _____

20. Registrar's license: _____

21. Registrar's commission: _____

22. Registrar's expiration: _____

23. Registrar's renewal: _____

24. Registrar's term: _____

25. Registrar's office: _____

26. Registrar's jurisdiction: _____

27. Registrar's authority: _____

28. Registrar's power: _____

29. Registrar's duty: _____

30. Registrar's responsibility: _____

31. Registrar's accountability: _____

32. Registrar's transparency: _____

33. Registrar's integrity: _____

34. Registrar's honesty: _____

35. Registrar's fairness: _____

36. Registrar's impartiality: _____

37. Registrar's objectivity: _____

38. Registrar's non-bias: _____

39. Registrar's non-discrimination: _____

40. Registrar's non-interference: _____

41. Registrar's non-intrusion: _____

42. Registrar's non-interference: _____

43. Registrar's non-intrusion: _____

44. Registrar's non-interference: _____

45. Registrar's non-intrusion: _____

46. Registrar's non-interference: _____

47. Registrar's non-intrusion: _____

48. Registrar's non-interference: _____

49. Registrar's non-intrusion: _____

50. Registrar's non-interference: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11790
CERTIFICATE OF DEATH

11722

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Washington D.C. 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS 1718--16th St., S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last LULA C. HENDRICKSON		4. DATE OF DEATH Month Day Year Oct. 18th 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20th, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Cronk		14. MOTHER'S MAIDEN NAME Mary A. Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Grace E. Seymour		Address -1718--16 St. SE Wash DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-15, 1959, to 10-18, 1959, that I last saw the deceased alive on 10-16, 1959, and that death occurred at 5:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John B Fegan M.D. 2210 Hudson St 10-18-59 PHYSICIAN'S NAME (Type) JOHN B FEGAN Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-59	
22c. NAME OF CEMETERY OR CREMATORY East Hill Cemetery		22d. LOCATION (City, town, or county) (State) Salem Va	
23. FUNERAL DIRECTOR'S SIGNATURE Seymour Bros. Funeral Home		ADDRESS 1661-6000 Hope Rd Wash DC SE	
24a. REC'D BY REGISTRAR DATE OCT 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

11723

Reg. Dist. No.

11736

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Ranier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 3402 Bunker Hill Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle H. Last Heyhoe				4. DATE OF DEATH Month October Day 23 Year 19 59			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-12-01	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George William Heyhoe				14. MOTHER'S MAIDEN NAME May Elizabeth Mapple			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial Infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2-hr 18-hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from 10-22 , 19 59 , to 10-23 , 19 59 , that I last saw the deceased alive on 10-23 , 19 59 , and that death occurred at 9:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED 10-23-59							
ACTUAL SIGNATURE Roy B. Parsons M.D.							
PHYSICIAN'S NAME (Type) Roy B. Parsons M.D., 4404 Queensbury Rd., Riverdale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/59		22c. NAME OF CEMETERY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE OCT 26 '59		24b. REGISTRAR'S SIGNATURE Carroll D. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO PRESS

11792

CERTIFICATE OF DEATH

11724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>		c. LENGTH OF STAY IN 1b <u>4 M</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7205 Glen Ridge Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael James</u> First Middle Last		4. DATE OF DEATH <u>10 23 1958</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-56</u>
9. AGE (In years last birthday) <u>3 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael James Horrigan</u>		14. MOTHER'S MAIDEN NAME <u>Elaine Baus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>7205 Glen Ridge Dr</u>	
17. INFORMANT <u>Father</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wilms Tumor</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 MO</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-28, 1958, to 10-23, 1958, that I last saw the deceased alive on 10-23-58, 1958, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Harold Y. Finck MD M.D. 1935 Good Hope Rd, SE Wash 200 ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type) HAROLD Y. FINCK, MD

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalby's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>mt. Rainier</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>
24c. ADDRESS <u>mt. Rainier</u>		24d. DATE <u>OCT 28 '59</u>	

11700

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 37 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3904 53rd Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Laura Last Hughes		4. DATE OF DEATH Month Oct Day 23 Year 19 59-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3, 1904
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	11. IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Issac Kingery		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Charles A Hughes		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema, severe 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Bronchitis and Asthma DUE TO (c) and Cor Pulmonale			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 , to Oct 23 , 19 59 , that I last saw the deceased alive on Oct 23 , 19 59 , and that death occurred at 3:20 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Road, Bladensburg, Maryland			
ACTUAL SIGNATURE William D. Rosson M.D.		DATE SIGNED 10/23/59	
PHYSICIAN'S NAME (Type) William D. Rosson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 26, 1959	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11726

11706

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>3718-35 St. Mt. Rainier</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>7 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>3718-35th street</u>			
3. NAME OF DECEASED (Type or print) <u>Ethel Collins Hunter</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Aug 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Morgantown W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard E. Collins</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Elizabeth Carney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-44-2038</u>		17. INFORMANT <u>Erwin G. Hunter</u> Address <u>3718-35</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1944</u> to <u>10 Oct.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 Oct.</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Mettingly M.D.</u>				ADDRESS (Street, city or town, state) <u>2200 R.T. Ave. N.E. W. DC</u>			
PHYSICIAN'S NAME (Type) <u>Thomas E. Mettingly, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

11727

11737

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 10 minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 6308 Patterson Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LAURA Middle BELLE Last HYNSON				4. DATE OF DEATH Month October Day 6th , Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 26th, 1875		9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Leedstown, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Unknown) Lamkin				14. MOTHER'S MAIDEN NAME Sarah Craft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Riverdale, Md. Doris L. Delano, 6308 Patterson St. East Pines,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 15 yrs 9 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-16 , 19 59 , to 10-6 , 19 59 that I last saw the deceased alive on 10-6-59 , 19 59 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hypocrite Rd DATE SIGNED 10-6-59							
ACTUAL SIGNATURE John P. Clum M.D.				PHYSICIAN'S NAME (Type) John P. Clum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/1959		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE OCT 8 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11738

CERTIFICATE OF DEATH

11729

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 3 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				02X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel Hospital				d. STREET ADDRESS 1101 Annapolis Blvd., E			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Rolley Jordan				4. DATE OF DEATH Month Day Year Oct. 21, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Company				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Jordan				14. MOTHER'S MAIDEN NAME Tennie Corvin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 410-28-7296		17. INFORMANT Vurl Jordan Address same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic + Renal Artery Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Generalized Arteriosclerosis 5 YRS (c) Diabetes Mellitus 5 YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic Ulcer 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18, 1959, to 10/21, 1959, that I last saw the deceased alive on 10/20, 1959, and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. M. Warren M.D. Laurel 10/21/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 23, 59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE OCT 23 '59		24b. REGISTRAR'S SIGNATURE William S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11739

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geo rges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Morley Middle Allan Last Jull Sr.				4. DATE OF DEATH Month Oct. Day 25 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 Aug 1885	
9. AGE (In years lost birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Professor U of Md		11. BIRTHPLACE (State or foreign country) Canada	
13. FATHER'S NAME John Henry Jull				14. MOTHER'S MAIDEN NAME Jane Winskell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Mrs Ma rion Louise Jull University Park Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intestinal Hemorrhage 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Carcinoma of the Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 12 hours unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-1 , 19 59 , to 10-25 , 19 59 , that I last saw the deceased alive on 10-25 , 19 59 , and that death occurred at 2:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walter B. Moyers M.D. 3503 Perry St Dr. W. Moyers., M.D. Mt. Rainier Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment				22b. DATE THEREOF Oct 27, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum	
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.				24a. REC'D BY REGISTRAR DATE OCT 27 '59			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24b. REGISTRAR'S SIGNATURE Hyattsville Md.			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11740 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11731

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6111 Kolb Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Venus First Middle Last				4. DATE OF DEATH October 20 19 59 Month Day Year			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1959	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR 7 Months 55 Days		IF UNDER 24 HRS. 55 Hours 55 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mason				14. MOTHER'S MAIDEN NAME Reather Gowan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Reather Kearse; same address as # 2. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY 19 Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 20, 1959 DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-23-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington ADDRESS 467 N. St NW, D.C.				24a. REC'D BY REGISTRAR OCT 23 '59		24b. REGISTRAR'S SIGNATURE Charles L. Keane	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of Birth: <u>1930-01-15</u></p>	
<p>5. Place of Birth: <u>New York City</u></p>		<p>6. Usual Residence: <u>123 Main St, Boston</u></p>	
<p>7. Cause of Death: <u>Myocardial Infarction</u></p>		<p>8. Manner of Death: <u>Natural</u></p>	
<p>9. Date of Death: <u>1975-03-10</u></p>		<p>10. Time of Death: <u>10:00 AM</u></p>	
<p>11. Signature of Medical Examiner: <u>[Signature]</u></p>		<p>12. Date of Examination: <u>1975-03-10</u></p>	
<p>13. Signature of Coroner: <u>[Signature]</u></p>		<p>14. Date of Filing: <u>1975-03-10</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
11741
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 14 Film G251 11-10-59 et
11732
11741
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Haward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>26 Yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sigbridge</u>		13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Girl Kessler</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-59</u>
9. AGE (In years last birthday) yrs. <u>26</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>26 hrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Brook Kessler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Grimes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>19-1941111111</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u>1941111111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastasis</u> <u>762.5</u> DUE TO <u>Neuroblastoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 10/1959</u> , 19, to <u>Oct 10/1959</u> , 19, that I last saw the deceased alive on <u>Oct 10/1959</u> , 19, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.		DATE SIGNED <u>Oct 10-1959</u>	
ACTUAL SIGNATURE <u>Robert O. Wingfield</u> M.D.		DATE SIGNED <u>Oct 10-1959</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT O. WINGFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 10, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lintheum Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksville MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert O. Wingfield</u> ADDRESS <u>Clarksville MD</u>		24a. REC'D BY REGISTRAR <u>Anthony G. Kessler</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>OCT 13 '59</u>	

2076194XU2

11742

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt 23 d. STREET ADDRESS 7 H Research Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Kiehn				4. DATE OF DEATH Month Day Year Oct 29 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1959	9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months Days Hours Min 3 6 38	IF UNDER 24 HRS. Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gunter Kiehn				14. MOTHER'S MAIDEN NAME Barbara, Leah Hutzler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address Mother			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 DUE TO atelectasis, bilateral, severe. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Tracheocephalic fistula DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 day 3 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Oct 29th , 19 59 , to Oct 29th , 19 59 , that I last saw the deceased alive on Oct 29th , 19 59 , and that death occurred at 5:55AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Till Bergemann		M.D. 4314 10 Oct 59		ADDRESS (Street, city or town, state) Hood River Maryland			
PHYSICIAN'S NAME (Type) Dr. Till Bergemann							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 11/12/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W Penn Jr		ADDRESS Administrator.		24a. REC'D BY REGISTRAR DATE NOV 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077261XU4

BY *W. L. GRIFFIN*, *Ph.D.*, *U.S. Bureau of Entomology and Plant Quarantine*

WASHINGTON, D. C., 1934

Published by the Government Printing Office

For sale by the Superintendent of Documents

Price 10 cents

Order from the Superintendent of Documents

Washington, D. C.

1934

U.S. GOVERNMENT PRINTING OFFICE

1934

U.S. GOVERNMENT PRINTING OFFICE

1934

11943
CENTRAL CITY, OHIO

RECEIVED
JAN 10 1943



11943
CENTRAL CITY, OHIO

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a letter or official communication.]

11744

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 3706 Ely Pl. S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle LOIS Last Liberatore				4. DATE OF DEATH Month Oct. Day 22 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/22		9. AGE (In years lost birthday) 37 yrs.	IF UNDER 1 YEAR Months 37 Days 37	IF UNDER 24 HRS. Hours 37 Min. 37
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME JAMES W. BECKETT				14. MOTHER'S MAIDEN NAME EMMA GILKOWAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT Address Dominic - Husband Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 645.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Ruptured tubal pregnancy DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/19 , 19 59 , to 10/22 , 19 59 , that I last saw the deceased alive on Oct. 22 , 19 59 , and that death occurred at 9:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. A. Holbrook		M.D. 4500 College Ave.		ADDRESS (Street, city or town, state) College Park, Md.		DATE SIGNED 10/23/59	
PHYSICIAN'S NAME (Type) Dr. Holbrook							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial 10/29/59		22b. DATE THEREOF 10/29/59		22c. NAME OF CEMETERY OR CREMATORY Mount Vista		22d. LOCATION (City, town, or county) (State) Bluefield W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chamber Co. Inc. 517 11th St. S.E.		ADDRESS 20c		24a. REC'D BY REGISTRAR DATE OCT 27 '59		24b. REGISTRAR'S SIGNATURE Cirhing S. Kross	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990

CERTIFICATE OF DEATH

Reg. Dist. No.

11735

11793

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5985 - Reamy Drive S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA First Middle M. Last LUTZ		4. DATE OF DEATH Oct. 5th. Month Oct. Day 5th. Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8-1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY New Jersey	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Lutz		14. MOTHER'S MAIDEN NAME Louisa M. Zeitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Edith L. Hobgood Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic-hypertensive heart disease 10yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25 , 19 49 , to Oct. 5 , 19 59 , that I last saw the deceased alive on Oct. 5 , 19 59 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Sacks		ADDRESS (Street, city or town, state) 3036 M Place, S.E. DATE SIGNED Oct. 5, 1959	
PHYSICIAN'S NAME (Type) Harry Sacks, M.D.		Washington 19, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 7-1959	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers ADDRESS 1661- G88d Hope Road S.E. Washington 20, D.C.		24a. REC'D BY REGISTRAR OCT 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

35711

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11745

CERTIFICATE OF DEATH

Reg. Dist. No.

11736

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, P.G. Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Lynch</u> Last <u>Lynch</u>				4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/30/73</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>13</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Alberta Booker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT <u>David Lynch</u> Address <u>6407 N st N.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 157x DUE TO <u>Carcinomatous</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma of pancreas</u> DUE TO (c) <u>Carcinoma of pancreas</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 9-</u> , 19 <u>59</u> , to <u>Oct. 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 13</u> , 19 <u>59</u> , and that death occurred at <u>6:20 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William B. Hagan</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. William B. Hagan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Benny Rd S.E. N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>467 N st. N.W. N.C.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hagan</u>	

11794

CERTIFICATE OF DEATH

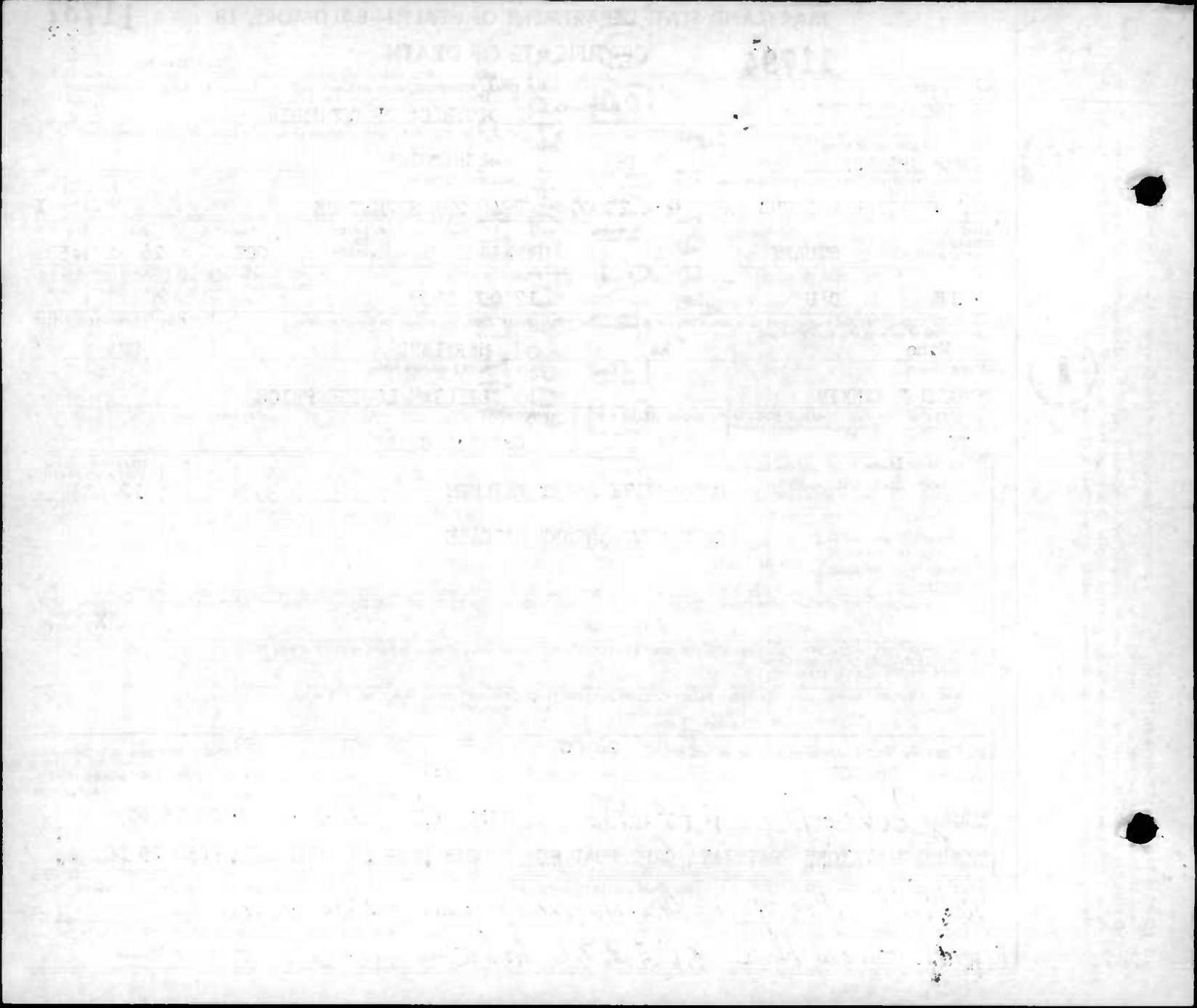
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS			c. LENGTH OF STAY IN 1b 7 HRS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS AAFB WASH 25 DC			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First STUART Middle A Last MANKIN			4. DATE OF DEATH Month OCT Day 26 Year 1959		
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 OCT 1959		9. AGE (In years lost birthday) yrs. 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME RONALD F MANKIN			14. MOTHER'S MAIDEN NAME LILLIAN LOUISE PRICE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NA		INFORMANT Address HOSPITAL CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CONGENITAL HEART DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 12 HRS					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 26 OCT , 19 59 , to 26 OCT , 19 59 , that I last saw the deceased alive on 26 OCT , 19 59 , and that death occurred at 7:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>Salvatore Battiatto</i> M.D. USAF HOSP ANDREWS AAFB WASH 25 DC PHYSICIAN'S NAME (Type) SALVATORE BATTIATA CAPT USAF MC USAF HOSP ANDREWS AAFB WASH 25 DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
22d. LOCATION (City, town, or county) ARLINGTON VA.		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Allen Hines</i>		ADDRESS 816 H St. N.E., Wash DC		24a. REC'D BY REGISTRAR DATE OCT 29 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050201XV6



11746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary E. Mc Bride</u>				4. DATE OF DEATH <u>Oct. 31</u> <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/10/92</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>? Conway</u>				14. MOTHER'S MAIDEN NAME <u>? McLish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <u>William S. Mc Bride</u> Son Address same				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 584X DUE TO <u>Pancreatitis with peripancreatic abscess 3 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholelithiasis</u> (c) <u>Encephalomalacia; Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Encephalomalacia; Generalized arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Oct 17</u> , 19 <u>59</u> , to <u>Oct 31</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>59</u> , and that death occurred at <u>6P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon W Kelley</u> M.D. <u>6129 41st Ave. Hyattsville, Md 10/31/59</u>				DATE SIGNED <u>10/31/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Gordon Kelley M.D.</u>				ADDRESS (Street, city or town, state) <u>6129 41st Ave. Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/4/1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. D.C.</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. J. Mattingly</u> ADDRESS <u>131-11th St. S.E.</u>				24a. REC'D BY REGISTRAR <u>NOV 3 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11238

CERTIFICATE OF DEATH

11238

Blank form with faint lines and text, likely a certificate of death.

CHIEF OF POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11739

Reg. Dist. No.

11694

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
c. LENGTH OF STAY IN lb 3 months				d. STREET ADDRESS 8700 49th Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8700 49th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irma Middle Virginia Last McCracken				4. DATE OF DEATH Month October Day 11 , Year 19 59			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-19-1912	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edgar M. Nussbaum				14. MOTHER'S MAIDEN NAME Elsie I. Beall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Warren Nussbaum; 4900 Ruatan Street, College Pk.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
				22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR OCT 16 '59 DATE	
				24b. REGISTRAR'S SIGNATURE Charles S. Haines			

CAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the instructions on the reverse side. Give pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

11-12-1912

11-12-1912

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11795

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X District Heights, Maryland			
c. LENGTH OF STAY IN 1b 25 yrs				d. STREET ADDRESS 7312 Grafton St., S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7312 Grafton St. SX				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle James Last Mc Geady				4. DATE OF DEATH Month Oct. Day 12 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1897	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours 19 Min.		IF UNDER 24 HRS. Months 12 Days 24 Hours 11 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph J. Mc Geady		14. MOTHER'S MAIDEN NAME Ann Keegan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. J. Mc Geady		Address 127 H. Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arterio sclerotic Heart Disease 6-7 yrs. DUE TO (c) Coronary atherosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 12-24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Oct. 9 , 19 55 to 12 Oct. , 19 59 , that I last saw the deceased alive on 21 Sept , 19 59 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state) 7200 Marlboro Pike, S.E.				DATE SIGNED 10-10-59			
ACTUAL SIGNATURE Sidney W. Lowry M.D.				PHYSICIAN'S NAME (Type) Sidney W. Lowry, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 10-15-1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl	
22d. LOCATION (City, town, or county) (State) DC				23. FUNERAL DIRECTOR'S SIGNATURE M. J. Mattingly			
ADDRESS 131-1126 H.S.E.				24a. REC'D BY REGISTRAR DATE OCT 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4 2 1

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11. See: Birth Cert., et

CERTIFICATE OF DEATH

Reg. Dist. No.

11741

11747

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 6 1/2 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, d. STREET ADDRESS 4900 Navahoe St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rhonda F McGhee				4. DATE OF DEATH Month Day Year October 20 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-59	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min. 1 29		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cheverly, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Raymond Brewer				14. MOTHER'S MAIDEN NAME Marvin McGhee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolytic imbalance 772.0 DUE TO Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Malnutrition. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/20 , 19 59 , to 10/20 , 19 59 , that I last saw the deceased alive on 10/20 , 19 59 , and that death occurred at 7:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5301 Hamilton St., Hyattsville 10/21/59 ACTUAL SIGNATURE John W. Perkins M.D. PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D. 5301 Hamilton St., Hyattsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
10-26-59		10-26-59		Loose		Muir Kirk MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jamieson Co ADDRESS 1432 You St. W. W.				24a. REC'D BY REGISTRAR DATE OCT 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1914

DATE OF DEATH _____ PLACE OF DEATH _____

DECEASED _____

CAUSE OF DEATH _____

AGE _____ SEX _____

RESIDENCE _____

DATE OF BIRTH _____

EDUCATION _____

PROFESSION _____

RELIGION _____

MARRIAGE _____

CHILDREN _____

PREVIOUS ILLNESS _____

PREVIOUS SURGERY _____

PREVIOUS TRAUMA _____

PREVIOUS DRUGS _____

PREVIOUS ACCIDENTS _____

PREVIOUS DEATHS _____

PREVIOUS MENTAL ILLNESS _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 14 Film G250 10-16-59 et

CERTIFICATE OF DEATH

11742

Reg. Dist. No.

11748

1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 39 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover				d. STREET ADDRESS 9028 Central Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Nelson Middle McGraw Last McGraw				4. DATE OF DEATH Month Oct Day 2 Year 1959				5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH July 24, 1908				9. AGE (In years last birthday) 51 yrs.				10. IF UNDER 1 YEAR Months 3 Days 10 Hours 15 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collector				10b. KIND OF BUSINESS OR INDUSTRY Potomac Electric Power Co				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Jackson Mc Graw				14. MOTHER'S MAIDEN NAME Collins, Rachael											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 11				INFORMANT Mary F. Mc Graw				Address Landover Md.				17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic CARCINOMA (c) 1 YEAR				INTERVAL BETWEEN ONSET AND DEATH 3 mos											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June , 19 55 , to OCT 2, 1959 that I last saw the deceased alive on OCT 2 , 19 59 , and that death occurred at 11:55 A.M. from the causes and on the date stated above.																ADDRESS (Street, city or town, state) 3503 Perry St.				DATE SIGNED 10/6/59											
ACTUAL SIGNATURE Norman D. Comeau				M.D. 3503 Perry St.				PHYSICIAN'S NAME (Type) Dr. Norman Comeau				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/5/59				22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				22d. LOCATION (City, town, or county) (State) Suitland Md.							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE OCT 5 '59				24b. REGISTRAR'S SIGNATURE Colbert A. Frank																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IT IS REQUESTED THAT YOU SIGN AND RETURN THIS CARD TO THE FOLLOWING ADDRESS:

11749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>4502 Emerson St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Levi</u> Middle <u>-</u> Last <u>McKinney</u>				4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 5, 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. Police</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>William McKinney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sherry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Hospital records</u>		Address <u>4408 Queensbury Rd., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>332x</u> DUE TO (c) <u>332x</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chromoblastitis Left leg</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>10</u> Day <u>11</u> Year <u>19 59</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>59</u> to <u>10-11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-11</u> , 19 <u>59</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4408 Queensbury Rd., Riverdale, Md.</u> DATE SIGNED <u>Roy B. Parsons</u>							
ACTUAL SIGNATURE <u>Roy B. Parsons</u> M.D. <u>4408 Queensbury Rd., Riverdale, Md.</u>				PHYSICIAN'S NAME (Type) <u>Roy B. Parsons, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 14, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G251 10-20-59 et

11744

11750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS 2603 Ohio Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julian E. Milton		4. DATE OF DEATH Month Day Year Oct. 23 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-82
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Auditor-U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Smithsonian Institution	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Milton		14. MOTHER'S MAIDEN NAME Elizabeth Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT Mrs. Archie Milton, wife		Address 1201-13th St. Wash. 5, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days 5 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/16 , 19 59 , to 10/23 , 19 59 that I last saw the deceased alive on 10/23 , 19 59 , and that death occurred at 8 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Dink Comeau		ADDRESS (Street, city or town, state) 3503 Perry St. Prince Georges Md	
PHYSICIAN'S NAME (Type) Dr Norman Comeau, M.D.		DATE SIGNED 10/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-27-59	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson, Co.		24a. REC'D BY REGISTRAR 1300-N St. NW WASH. D.C.	
24b. REGISTRAR'S SIGNATURE Oct 26 '59		24c. REGISTRAR'S SIGNATURE Arthur S. Kline	

11250

x

7

John Wilson - ...

Illinois

Elizabeth Collins

John Wilson

John Wilson - ...

no

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		c. LENGTH OF STAY IN 1b 2 years 34 Brentwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3713 Taylor Street		d. STREET ADDRESS 3713 Taylor Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Michael Murchake		4. DATE OF DEATH Month October Day 11 Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-76
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Murchake		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-4312	
17. INFORMANT Mary Anna Hennies; same address.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR OCT 13 1959		24b. REGISTRAR'S SIGNATURE	
DATE			

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		Male		45		1-1-1900		Baltimore, Md.		Carpenter	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
1234 E. Lombard St.		1-15-1945		Home		Myocardial Infarction		Natural		None	
PREVIOUS ILLNESS		TREATMENT		POST-MORTEM EXAMINATION		LABORATORY EXAMINATION		TOXICOLOGICAL EXAMINATION		OTHER	
None		None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		PLACE		TITLE		HOSPITAL		CITY	
J. H. Smith		1-16-1945		Baltimore		M.D.		None		None	
FAMILY PHYSICIAN		DATE		PLACE		TITLE		HOSPITAL		CITY	
None		None		None		None		None		None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G250 10-27-59 et

11746

11752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Naehrlich Last Naehrlich		4. DATE OF DEATH Month Oct. Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/83
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Massachusetts
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Carl Simak Naehrlich	
14. MOTHER'S MAIDEN NAME Sophia Weiser		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Ruth Stancil Daughter Horseshoe Dr. Clinton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO Pulmonary Embolism (c) Pulmonary Embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/30/59 , 19 59 , to 10/19/59 , 19 59 , that I lost saw the deceased alive on 10/19/59 , 19 59 , and that death occurred at 8:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Irvin M. Grassgreen M.D. 3101 ARUNDEL RD.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN MD		MT. RAINIER, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/59	
22c. NAME OF CEMETERY OR CREMATORY Ridgefield Cemetery		22d. LOCATION (City, town, or county) (State) Ridgefield New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR OCT 22 '59 24b. REGISTRAR'S SIGNATURE Wm. S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11783

Given at _____
this _____ day of _____
19____

I, _____
of the County of _____
State of _____

do hereby certify that _____
born _____
died _____

at _____
the cause of death being _____
as shown by the _____

and that the death was caused by _____
and not by _____

and that the death was not caused by _____
and not by _____

and that the death was not caused by _____
and not by _____

and that the death was not caused by _____
and not by _____

and that the death was not caused by _____
and not by _____

and that the death was not caused by _____
and not by _____

and that the death was not caused by _____
and not by _____

CERTIFICATE OF DEATH

Reg. Dist. No.

11753

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Newton				4. DATE OF DEATH Month October Day 8 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/08	9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Foundry Worker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Wm H - Newton				14. MOTHER'S MAIDEN NAME MARGARET MCALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		INFORMANT ALICE Address Alice Newton Sister Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intracerebral hemorrhage DUE TO 5 days (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 3, 1959 , to October 8, 1959 , that I last saw the deceased alive on October 8, 1959 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Road, Bladensburg, Maryland					
PHYSICIAN'S NAME (Type) Dr. Rosson, William D.		DATE SIGNED 10/9/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) 1		22b. DATE THEREOF OCT 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) WASH. DC	
23. FUNERAL DIRECTOR'S SIGNATURE W W Tattum				ADDRESS 3603 14th Ave NW		24a. REC'D BY REGISTRAR OCT 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur & House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

225

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11748

1. PLACE OF DEATH <u>3304 LANCER DR.</u> a. COUNTY <u>TR. GEO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PR GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD.</u>	c. LENGTH OF STAY IN 1b <u>11 MOS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 COLLEGE PARK.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SAME; CUMMIS NURSING HOME</u>		d. STREET ADDRESS <u>4820 OSAGE ST.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>PATRICIA ANN NORRIS</u>		4. DATE OF DEATH Month Day Year <u>OCT. 25 19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Apr '48</u>
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>WASH. DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CARLTON L NORRIS</u>	
14. MOTHER'S MAIDEN NAME <u>KELIA LONGLEY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>mother — above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION</u> DUE TO <u>351X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INANITION</u> DUE TO (c) <u>CEREBRAL PALSY — TETRAPLEGIC</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>LIFE</u> <u>LIFE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Nov</u> , 19 <u>58</u> to <u>25 Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>25 Oct</u> , 19 <u>59</u> , and that death occurred at <u>11:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph J. McDonald</u>		ADDRESS (Street, city or town, state) <u>7309 REES RD. ADELPHI, MD.</u>	
DATE SIGNED <u>25 Oct 59</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH J. McDONALD MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Hill Cent.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Lee</u>		ADDRESS <u>Wash D. C.</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Ciribus S. Kasse</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11749

11702

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1807 Fox Street		d. STREET ADDRESS 1807 Fox Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Verónica O'Reilly		4. DATE OF DEATH Month Day Year October 19, 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Ryan		14. MOTHER'S MAIDEN NAME Mary E. Breen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Eugene N. O'Reilly; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Corronary Occlusim DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Corronary thrombosis DUE TO (c) Cardiovascular renal disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver, cerebral edema .			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 19, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/21/59	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WARNER E. PUMPHREY, INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE OCT 23 '59	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11754

CERTIFICATE OF DEATH

Reg. Dist. No.

11750

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>P.H.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>				c. LENGTH OF STAY IN 1b <i>D.O.A.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Hospital</i>				e. STREET ADDRESS <i>4235 - 71st Ave.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Clarence Vernon Pearson</i>				4. DATE OF DEATH Month Day Year <i>October 12, 1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JAN. 19/1890</i>	
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST (RETIRED)</i>		11. BIRTHPLACE (State or foreign country) <i>MAINE</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST (RETIRED)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. NAVY VET</i>		11. BIRTHPLACE (State or foreign country) <i>MAINE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME <i>EVELYN HATTIE (UNKNOWN)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>MYRA H. PEARSON</i>		Address <i>4235 - 71st Ave., MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Oedema</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Failure</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>6 mo. +</i> <i>2 years +</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hernia repair followed by exploration of abdomen for Ca</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June</i> , 1935, to <i>Sept.</i> , 1959, that I last saw the deceased alive on <i>Sept. 1</i> , 1959, and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Karl Dorfzbach</i> M.D.				ADDRESS (Street, city or town, state) <i>Washington Clinic</i> DATE SIGNED <i>10/12/59</i>			
PHYSICIAN'S NAME (Type) <i>Karl Dorfzbach M.D.</i>				Wise + Western Ave. N.W., Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/16/1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>COLUMBIA MARYLAND PRGE CO MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS Co - RIVERDALE, MD</i>				24a. REC'D BY REGISTRAR DATE <i>OCT 15 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Finner</i>	

CERTIFICATE OF DEATH

11754

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR OF HAIR Brown		9. COLOR OF EYES Blue		10. COLOR OF SKIN Caucasian	
11. PLACE OF DEATH Baltimore, Md.		12. DATE OF DEATH 4/4/68		13. TIME OF DEATH 10:00 AM		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CORONER		20. SIGNATURE OF REGISTRAR	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11751

Reg. Dist. No.

11796

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>		c. LENGTH OF STAY IN 1b <u>9 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5481 Glenhill Road</u>				d. STREET ADDRESS <u>5481 Glenhill Road</u>			
3. NAME OF DECEASED (Type or print) <u>John Aubrey Powell</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>January 29, 1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>					
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>John G. Powell 52501 Littleton Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Oct 10, 1959</u>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CAKWOOD CEMETERY RICHMOND VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. L. L. C.</u>		ADDRESS <u>300 4th ST N.W.</u>		24a. REC'D BY REGISTRAR <u>OCT 15 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG250 10-26-59 et

CERTIFICATE OF DEATH

11752

Reg. Dist. No.

11755

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 75 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 6219 L St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle E Last Puller				4. DATE OF DEATH Month Oct. Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 Sept. 1916	
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 47 Days 11 Hours 15 Min.		11. IF UNDER 24 HRS. Months 47 Days 11 Hours 15 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
13. FATHER'S NAME Eugene Puller				14. MOTHER'S MAIDEN NAME Bertha L. Page			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 10/1/43-6/8/46			
17. INFORMANT Edna Puller				Address Cedar Hgts. 6219 L St., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile Coronary Arteriosclerosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction old. B. Myocardial infarction old.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-23 , 19 59 , to Oct. 7 , 19 59 , that I last saw the deceased alive on Oct. 6 , 19 59 , and that death occurred at 7:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hans Wodak				ADDRESS (Street, city or town, state) 30 E Bridge Rd, Greenbelt, Md 20780			
PHYSICIAN'S NAME (Type) Dr Hans Wodak, M.D.				DATE SIGNED Oct 13 59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-12-59			
22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) (State) Arlington, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Collins				ADDRESS 4339 Hunt Pk. N.E.			
24a. REC'D BY REGISTRAR OCT 13 59				24b. REGISTRAR'S SIGNATURE Arthur S. Fries			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1755

CERTIFICATE OF DEATH

1755

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Jan 1, 1912		New York City		Heart Disease		J. Smith		A. Jones	
Occupation		Residence		Marital Status		Religion		Burial Place		Date of Burial		Name of Burial Place		Signature of Burial Officer		Signature of Minister	
Teacher		123 Main St.		Married		Catholic		St. Mary's		Jan 5, 1912		St. Mary's		B. Green		C. White	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Exhumation		Date of Reinterment	
Jan 1, 1867		New York City		Jan 1, 1912		Jan 1, 1912		Jan 1, 1912		Jan 5, 1912		Jan 5, 1912		Jan 5, 1912		Jan 5, 1912	

CERTIFICATE OF DEATH

Reg. Dist. No.

11756

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Richardson		4. DATE OF DEATH Month Oct Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/59
9. AGE (In years last birthday) — yrs.		10. IF UNDER 1 YEAR Months — Days — Hours 13 Min.	11. IF UNDER 24 HRS. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Boyd F. Richardson	
14. MOTHER'S MAIDEN NAME Virginia E. Hamm		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address Virginia E. Mother Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 19, 1959 to Oct 19, 19 59 that I last saw the deceased alive on Oct 19, 19 59 , and that death occurred at 8:30P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John Perkins		ADDRESS (Street, city or town, state) DATE SIGNED 5301 Hawthorn St., Hyattsville 19	
PHYSICIAN'S NAME (Type) John Perkins M.D.		M.D. 11/9	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 10/28/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077254XVO

CERTIFICATE OF DEATH

1935

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PROPERTY

DEBTS

ESTATE

WILLS

TESTAMENTS

ADMINISTRATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11754

11757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Richardson		4. DATE OF DEATH Month Day Year October 13 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 June 1880
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Painter, Paper Hanger	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Elizabeth Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Son, W.R. Richardson, 412, 61st Ave. Md.		Address Capitol Hghts	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcophallo malacia Respiratory (c) Arterio sclerosis heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:25 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon W. Kelley M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 6124-41st Ave Hyattsville Md 10/13/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee		ADDRESS Wash D.C.	
24a. REC'D BY REGISTRAR DATE OCT 15 '59		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

11752

11751

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

County of _____

City of _____

State of _____

Decedent's Name _____

Sex _____

Age _____

Married _____

Occupation _____

Place of Birth _____

Date of Birth _____

Time of Death _____

Place of Death _____

Cause of Death _____

Signature of Physician _____

Signature of Registrar _____

Date _____

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11758

CERTIFICATE OF DEATH

11755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 da. 14 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 5415 Tilden Street	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Auteri Rinaldi		4. DATE OF DEATH Month Day Year October 7 1959		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 25, 1905		9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francesco Auteri		14. MOTHER'S MAIDEN NAME ROSARIA AUTERIA		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 579-24-0575		17. INFORMANT ANGELO RINALDI	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple arterial emboli (c) Aneurysm Rupture Rheumatic disease.		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs 45 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/5, 1957, to 10/7, 1959, that I last saw the deceased alive on 10/7, 1959, and that death occurred at 11:40 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 63000 Riverdale Road, Riverdale, Md.		DATE SIGNED John Kehoe		22a. BURIAL, CREMATION, REMOVAL (Specify) 10/10/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St. Elizabeth's Cemetery		22d. LOCATION (City, town, or county) Calver Manor Md		23. FUNERAL DIRECTOR'S SIGNATURE J. W. [Signature]		24a. REC'D BY REGISTRAR DATE OCT 13 59		24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	



NEW SOUTH WALES

DEATH

IN THE DISTRICT OF

LOCALITY

RESIDENCE

DECEASED

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

PERIOD OF ILLNESS

DATE OF DEATH

SIGNATURE OF REGISTRAR

1917

11

1171

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11759

CERTIFICATE OF DEATH

11756

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>LAUREL SANITARIUM</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	c. LENGTH OF STAY IN 1b <u>adm 6-16-59</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		d. STREET ADDRESS <u>—</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MAR</u> First <u>GARET</u> Middle <u>ANN</u> Last <u>ROBERTSON</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>15</u> - Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7 - 1891</u>
9. AGE (In years, lay birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>not any</u>	
11. BIRTHPLACE (State or foreign country) <u>BROOKLYN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES McKeown</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE Whalen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hosp. Records</u>		Address <u>LAUREL SANITARIUM</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FIBRILLATION</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>433.1</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>433.1 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SCHIZOPHRENIC DISORDER (PARANOID TYPE)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> o. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>Oct - 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct - 15</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lillian P. Krucinski</u> M.D.		ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u>	
DATE SIGNED <u>10-15-59</u>		DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/20/59</u>	22b. DATE THEREOF <u>10/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Clinton Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEE FUNERAL HOME</u>		ADDRESS <u>300 4th ST NE</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>OCT 20 '59</u>		DATE <u>—</u>	

11757

11707

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN 1b 10 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4201-28th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillie M. Ryan		4. DATE OF DEATH Oct. 9th 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 11, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY IN OWN HOME	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONSTANTINE HUTTON		14. MOTHER'S MAIDEN NAME CLEMENTINE ANDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address CORNELIUS S. RYAN - AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA (c) INTERVAL BETWEEN ONSET AND DEATH 1 DAY 5 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to 9 OCT. 1959, that I last saw the deceased alive on 9 OCT. 1959, and that death occurred at 2:50 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry R. Wolfe		ADDRESS (Street, city or town, state) DATE SIGNED 905 SHERIDAN ST. 10/9/59	
PHYSICIAN'S NAME (Type) HENRY R. WOLFE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-12-1959	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc.		24a. REC'D BY REGISTRAR ADDRESS Mt. Rainier Md. DATE OCT 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

505

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11760

11759

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>47</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>				d. STREET ADDRESS <u>510 - Eye Street N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Nothman</u> Last <u>Sanders</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 7, 1886</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Sanders</u>				14. MOTHER'S MAIDEN NAME <u>Lena Cohen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Jack Sanders</u> Address <u>15 Redgate Greenbelt Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHEV. SH. GLOM. TRL. MD. TORAH CEMETERY</u>		22d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Nanzanovsky + Son</u>				ADDRESS <u>3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEWYORK STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11761

CERTIFICATE OF DEATH

11760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2601 Cheverly Ave., Adsacorda Convalescent Home		d. STREET ADDRESS 9207 Lanham Severn Road	
3. NAME OF DECEASED (Type or print) First BERNICE Middle GUELLEN Last SMITH		4. DATE OF DEATH Month October Day 23rd , Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7th, 1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife- Retired		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Meadow Bluff, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moss Freshman		14. MOTHER'S MAIDEN NAME Fannie Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Howard T. Smith, 9207 Lanham Severn Rd., Lanham		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia 443X DUE TO Chronic Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Atherosclerotic Heart Disease (c) Generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week several weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , to 10/23 , 19 59 , that I last saw the deceased alive on 10/22 , 19 59 , and that death occurred at 6:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		ADDRESS (Street, city or town, state) R. F. D. Bowie Md 10/23/59	
PHYSICIAN'S NAME (Type) H. James Kurtz		DATE SIGNED 10/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR OCT 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			

CERTIFICATE OF DEATH

11561

Page Two

PLACE OF DEATH At Home		DECEASED James George	
1. DATE OF DEATH October 2, 1922		2. TIME OF DEATH 3:00 PM	
3. PLACE OF DEATH At Home		4. CAUSE OF DEATH Cerebral Hemorrhage	
5. PLACE OF DEATH At Home		6. PLACE OF DEATH At Home	
7. PLACE OF DEATH At Home		8. PLACE OF DEATH At Home	
9. PLACE OF DEATH At Home		10. PLACE OF DEATH At Home	
11. PLACE OF DEATH At Home		12. PLACE OF DEATH At Home	
13. PLACE OF DEATH At Home		14. PLACE OF DEATH At Home	
15. PLACE OF DEATH At Home		16. PLACE OF DEATH At Home	
17. PLACE OF DEATH At Home		18. PLACE OF DEATH At Home	
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37. PLACE OF DEATH At Home		38. PLACE OF DEATH At Home	
39. PLACE OF DEATH At Home		40. PLACE OF DEATH At Home	
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43. PLACE OF DEATH At Home		44. PLACE OF DEATH At Home	
45. PLACE OF DEATH At Home		46. PLACE OF DEATH At Home	
47. PLACE OF DEATH At Home		48. PLACE OF DEATH At Home	
49. PLACE OF DEATH At Home		50. PLACE OF DEATH At Home	
51. PLACE OF DEATH At Home		52. PLACE OF DEATH At Home	
53. PLACE OF DEATH At Home		54. PLACE OF DEATH At Home	
55. PLACE OF DEATH At Home		56. PLACE OF DEATH At Home	
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69. PLACE OF DEATH At Home		70. PLACE OF DEATH At Home	
71. PLACE OF DEATH At Home		72. PLACE OF DEATH At Home	
73. PLACE OF DEATH At Home		74. PLACE OF DEATH At Home	
75. PLACE OF DEATH At Home		76. PLACE OF DEATH At Home	
77. PLACE OF DEATH At Home		78. PLACE OF DEATH At Home	
79. PLACE OF DEATH At Home		80. PLACE OF DEATH At Home	
81. PLACE OF DEATH At Home		82. PLACE OF DEATH At Home	
83. PLACE OF DEATH At Home		84. PLACE OF DEATH At Home	
85. PLACE OF DEATH At Home		86. PLACE OF DEATH At Home	
87. PLACE OF DEATH At Home		88. PLACE OF DEATH At Home	
89. PLACE OF DEATH At Home		90. PLACE OF DEATH At Home	
91. PLACE OF DEATH At Home		92. PLACE OF DEATH At Home	
93. PLACE OF DEATH At Home		94. PLACE OF DEATH At Home	
95. PLACE OF DEATH At Home		96. PLACE OF DEATH At Home	
97. PLACE OF DEATH At Home		98. PLACE OF DEATH At Home	
99. PLACE OF DEATH At Home		100. PLACE OF DEATH At Home	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11704
CERTIFICATE OF DEATH

11761

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6002 35th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Gertrude Middle Keck Last Smith		4. DATE OF DEATH Month Oct. Day 9 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/ 1879
9. AGE (In years last birthday) 80 yrs.		10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13. FATHER'S NAME David Keck		14. MOTHER'S MAIDEN NAME Mary Morton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-03-3866B	
17. INFORMANT Mrs. Hazel S. Cones -		Address 6002- 35th Ave Hyattsville Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myeloid Leukemia 2041 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) _____ (County) _____ (State) _____			

21. I certify that I attended the deceased from 11-30 , 19 54 , to 10-9 , 19 59 , that I last saw the deceased alive on 10-5 , 19 59 , and that death occurred at 12:45 AM , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
ACTUAL SIGNATURE Waldo B. Moyers M.D. 3503 Perry St 10-9-59	
PHYSICIAN'S NAME (Type) Waldo B. Moyers Mt. Rainier Md	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 12/ 59	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR OCT 13 '59	24b. REGISTRAR'S SIGNATURE Arthur A. Tread

TO HO...
ENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death.
may be retained...
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

Princess George's

Weymouth

4002-251 Ave.

Smith

11504

Ohio

Mary Norton

4002-251 Ave.

Weymouth

Princess George's

Weymouth

Weymouth

Weymouth

Weymouth

Weymouth

Weymouth

Weymouth

Weymouth

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11762

Reg. Dist. No.

11708

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier			c. LENGTH OF STAY IN 1b 23yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4200 31st Street				d. STREET ADDRESS 4200 31st Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Harold Spilman				4. DATE OF DEATH Month Day Year October 20 1959			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-05		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Spilman				14. MOTHER'S MAIDEN NAME Grace Brickard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2. 578-01-1066		17. INFORMANT Address Robert Spilman; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion (c), stating the underlying cause last. Coronary thrombosis. </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 20, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home Inc.				24a. REC'D BY REGISTRAR ADDRESS Mt Rainier Md. DATE OCT 23 '59		24b. REGISTRAR'S SIGNATURE William S. Knecht	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G251 11-4-59 et

11763

11706

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paintbrush Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16 d. STREET ADDRESS 3112-Hebster St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mattie B. Spittler		4. DATE OF DEATH Month Day Year 10/27 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/1867
9. AGE (In years, last birthday) 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Luray, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Reuben Long		14. MOTHER'S MAIDEN NAME Esther Huffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Ida E. McKeown, Daughter 3112-Hebster St. Mt. Rainier Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Carcinoma of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 mos. 23 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/4, 1959, to 10/27, 1959, that I last saw the deceased alive on 10/27, 1959, and that death occurred at 11:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl W. Graeff		DATE SIGNED 27/10/1959	
PHYSICIAN'S NAME (Type) EARL W. GRAEFF, M.D.		W. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Luray, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE OCT 30 '59	
ADDRESS Mt. Rainier, Md.		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

11702

11702

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11695

CERTIFICATE OF DEATH

11764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8811 Rhode Island ave		e. STREET ADDRESS 8811 Rhode Island avenue	
3. NAME OF DECEASED (Type or print) Charlie Ross Stanley		4. DATE OF DEATH Month October Day 29 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14, 1885
9. AGE (In years birth day yrs.) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William Charles Stanley	
14. MOTHER'S MAIDEN NAME Martha Ann Riner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Emma Sims College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 21, 1958 to Oct 29, 1959 , that I last saw the deceased alive on Oct 21, 1959 , and that death occurred at 9a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. W. Malin		DATE SIGNED 10-29-59	
PHYSICIAN'S NAME (Type) L. W. Malin M.D.		ADDRESS (Street, city or town, state) Riverdale, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 31, 1959	
22c. NAME OF CEMETERY OR CREMATOR George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

11784

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

11785

1. PLACE OF DEATH		2. PLACE OF BIRTH	
HOME		BALTIMORE, MARYLAND	
3. DATE OF DEATH		4. TIME OF DEATH	
JANUARY 1, 1900		10:00 AM	
5. NAME OF DECEASED		6. SEX	
JOHN J. JONES		MALE	
7. AGE		8. OCCUPATION	
35 YEARS		LABORER	
9. CAUSE OF DEATH		10. MEDICAL HISTORY	
HEART DISEASE		NONE	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
J. J. JONES, M.D.		J. J. JONES, M.D.	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY	
BALTIMORE		BALTIMORE	
15. NAME OF FUNERAL HOME		16. NAME OF UNDERTAKER	
J. J. JONES		J. J. JONES	
17. NAME OF MINISTER		18. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
19. NAME OF CLERGYMAN		20. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
21. NAME OF CLERGYMAN		22. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
23. NAME OF CLERGYMAN		24. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
25. NAME OF CLERGYMAN		26. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
27. NAME OF CLERGYMAN		28. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
29. NAME OF CLERGYMAN		30. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
31. NAME OF CLERGYMAN		32. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
33. NAME OF CLERGYMAN		34. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
35. NAME OF CLERGYMAN		36. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
37. NAME OF CLERGYMAN		38. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
39. NAME OF CLERGYMAN		40. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
41. NAME OF CLERGYMAN		42. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
43. NAME OF CLERGYMAN		44. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
45. NAME OF CLERGYMAN		46. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
47. NAME OF CLERGYMAN		48. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
49. NAME OF CLERGYMAN		50. NAME OF CHURCH	
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51. NAME OF CLERGYMAN		52. NAME OF CHURCH	
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53. NAME OF CLERGYMAN		54. NAME OF CHURCH	
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61. NAME OF CLERGYMAN		62. NAME OF CHURCH	
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67. NAME OF CLERGYMAN		68. NAME OF CHURCH	
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75. NAME OF CLERGYMAN		76. NAME OF CHURCH	
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77. NAME OF CLERGYMAN		78. NAME OF CHURCH	
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J. J. JONES		J. J. JONES	
97. NAME OF CLERGYMAN		98. NAME OF CHURCH	
J. J. JONES		J. J. JONES	
99. NAME OF CLERGYMAN		100. NAME OF CHURCH	
J. J. JONES		J. J. JONES	

11703

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville/ Washington, D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home 5805 Queens Chapel Rd.				d. STREET ADDRESS 4130 "W" St., N. W. 5805 Queens Chapel Road			
3. NAME OF DECEASED (Type or print) First Middle Last Mattie R. St. Clair				4. DATE OF DEATH Month Day Year Oct. 6, 1959 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/71	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senior auditor Post Office Dept				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Charles County, Md.	
13. FATHER'S NAME Lewis St. Clair				14. MOTHER'S MAIDEN NAME Elizabeth Lee Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Dr. Regis Boyle 3026 Legation St. N.W. Washington 9, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cerebral Vascular Hemorrhage DUE TO INTERVAL BETWEEN ONSET AND DEATH 33/X 3 days 3 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/27/1953, 19 to 10/6/1959, that I last saw the deceased alive on 10/5/1959, 19, and that death occurred at 12:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. 322- H. Street, N.E.							
ACTUAL SIGNATURE Thomas F. Collins				M.D. 322- H. Street, N.E.			
PHYSICIAN'S NAME (Type) Dr. Thomas F. Collins				Washington 2, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1473

1100

1. NAME OF DECEASED JAMES H. COLLINS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 10/15/1895	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Retired		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 12/15/1915	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Cerebral Vascular Hemorrhage		11. ICD-9 CODE 430.91		12. DATE OF DEATH 10/15/1960	
13. TIME OF DEATH 12:15 A.M.		14. SIGNATURE OF PHYSICIAN J. H. Collins		15. SIGNATURE OF WITNESS J. H. Collins		16. SIGNATURE OF DECEASED J. H. Collins	
17. PLACE OF INTERMENT St. John's Cemetery		18. NAME OF INTERMENT HOME St. John's Cemetery		19. NAME OF FUNERAL HOME St. John's Cemetery		20. NAME OF FUNERAL HOME St. John's Cemetery	
21. NAME OF FUNERAL HOME St. John's Cemetery		22. NAME OF FUNERAL HOME St. John's Cemetery		23. NAME OF FUNERAL HOME St. John's Cemetery		24. NAME OF FUNERAL HOME St. John's Cemetery	
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97. NAME OF FUNERAL HOME St. John's Cemetery		98. NAME OF FUNERAL HOME St. John's Cemetery		99. NAME OF FUNERAL HOME St. John's Cemetery		100. NAME OF FUNERAL HOME St. John's Cemetery	

11797

CERTIFICATE OF DEATH

Reg. Dist. No.

11765

1. PLACE OF DEATH a. COUNTY Glenn Dale Hospital Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 612 Eye Street, S.E.	
3. NAME OF DECEASED (Type or print) First Susie Middle C. Last Sturgess		4. DATE OF DEATH Month 10 Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 25, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John S. King		14. MOTHER'S MAIDEN NAME Kate Turpin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-32-8624	
17. INFORMANT Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis Far Advanced DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) 002X DUE TO (c) 002X		INTERVAL BETWEEN ONSET AND DEATH 4 yrs, 8 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure ; Bronchial Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4 , 19 55 , to October 25 , 19 59 , that I last saw the deceased alive on October 25 , 19 59 , and that death occurred at 7:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		DATE SIGNED 10/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-25-59	
22c. NAME OF CEMETERY OR CREMATORY Wash. D.C.		22d. LOCATION (City, town or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees		24a. REC'D BY REGISTRAR DATE OCT 27 '59	
ADDRESS 306-4th St. N.E. Wash. D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kins	

VS A15 (4)
ISM 9/58

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11762

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>8 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. STREET ADDRESS <u>Rt. 2 Box 61</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Owen Tippet</u>				4. DATE OF DEATH Month Day Year <u>Oct 5 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 26, 1959</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Bernard Tippet</u>				14. MOTHER'S MAIDEN NAME <u>Betty Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Father</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>571.0</u> DUE TO <u>Dehydration</u> IMMEDIATE CAUSE (a) <u>Gastroenteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/4</u> , 19 <u>59</u> , to <u>10/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/5</u> , 19 <u>59</u> , and that death occurred at <u>12:10AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamulla St., Hyattsville, Md.</u> DATE SIGNED <u>10/5/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. John Perkins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2177284XV4

TESTIFICATE OF DEATH

11762

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF DECEASED

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF WITNESSES

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF DECEASED

DATE OF SIGNATURE

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SIGNATURE OF DECEASED

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SIGNATURE OF DECEASED

DATE OF SIGNATURE

PLACE OF SIGNATURE

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11763

CERTIFICATE OF DEATH

Reg. Dist. No.

11767

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly d. STREET ADDRESS 6016 Hawthorne St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Edward First W Middle Todd Last		4. DATE OF DEATH Month Oct. Day 5 Year 19 59		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-22-76		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman				10b. KIND OF BUSINESS OR INDUSTRY Auto.				11. BIRTHPLACE (State or foreign country) Ill.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward W. Todd				14. MOTHER'S MAIDEN NAME Alice Weigley				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None				17. INFORMANT Address Bethany T. Holcombe Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Shunt bolus occlusion of the Rt. int. carotid Ar. DUE TO (b) Cerebral & generalized arteriosclerosis. DUE TO (c) 5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/25/59 , 19 59 , to Oct. 5 , 19 59 , that I last saw the deceased alive on Oct 5 , 19 59 , and that death occurred at 11:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale Maryland DATE SIGNED 10/5/59 ACTUAL SIGNATURE John Kehoe M.D. PHYSICIAN'S NAME (Type) John Kehoe																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 10/6/59				22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory				22d. LOCATION (City, town, or county) (State) Clomar Manor Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland				24a. REC'D BY REGISTRAR OCT 13 '59				24b. REGISTRAR'S SIGNATURE Arthur J. Hines							

11763

CERTIFICATE OF DEATH

11763

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

CERTIFICATE OF DEATH

Reg. Dist. No.

11768

11764

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Hr 15 Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Tolson Last Tolson		4. DATE OF DEATH Month October Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/59
9. AGE (In years lost birthday) 3 Mos		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	11. IF UNDER 24 HRS. Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Ashbey Tolson		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mary Mother - Address same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte imbalance 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration DUE TO (c) Enterocolitis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/29/59 , 19____, to 10/29/59 , 19____, that I last saw the deceased alive on 10/29/59 , 19____, and that death occurred at 7:15 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hawth St., Hyattsville DATE SIGNED 10/30/59	
PHYSICIAN'S NAME (Type) Dr. John Perkins			
22a. BURIAL, CREMATION, REMOVAL (Specify) Nov. 3 - 1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Perkins ADDRESS 4804 Pa. Ave. N.W.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077206XU5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11769

11765

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		d. STREET ADDRESS 3600 52nd St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Frank E Vanderhoof		4. DATE OF DEATH Month Day Year Oct 27 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1888		9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Publisher		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Frank F Vanderhoof		14. MOTHER'S MAIDEN NAME Kathleen Birdsall		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and bronchopneumonia 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Pulmonary emphysema, bullous DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hours years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric ulcer, prepyloric with hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:10AM , from the causes and on the date stated above.		DATE SIGNED Irvin M. Grassgreen		ADDRESS (Street, city or town, state) 3101 ARUNDEL RD		22a. REC'D BY REGISTRAR DATE OCT 30 1959		22b. REGISTRAR'S SIGNATURE MT. RAINIER, MD		22c. NAME OF CEMETERY OR CREMATORY The Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Bronx, New York		23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 30 1959		24b. REGISTRAR'S SIGNATURE Oct 30 1959	

2

077

CERTIFICATE OF DEATH

11502

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
11766
MARYLAND STATE DEPARTMENT OF RESIDENT OF HEALTH—BALTIMORE, 18
Item 14 Film G250 10-27-59 et
11770
CERTIFICATE OF DEATH
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 6 hrs 40 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 14 d. STREET ADDRESS 7319 Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Walker		4. DATE OF DEATH Month Day Year Oct 9 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1959
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months Days 6 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert C. Walker		14. MOTHER'S MAIDEN NAME Margaret A. Youmans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Father	
17. INFORMANT Father		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congestive Heart Disease DUE TO (b) Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis; Prematurity			
INTERVAL BETWEEN ONSET AND DEATH 6 hrs, 40 min. 6 hrs, 40 min.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 8, 1959 to Oct. 9, 1959 that I last saw the deceased alive on Oct. 9, 1959 , and that death occurred at 1:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Mary K. L. Sartwell		ADDRESS (Street, city or town, state) 6811 Ridge Rd., Hyattsville, Md.	
DATE 10/10/59		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. John Haught			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Oct 19 1959	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
ADDRESS Administrator		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

2077182XV2

11270

STATE OF NEW YORK

IN SENATE

1898

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

FOR THE YEAR

1897

ALBANY:

1898

BY

JOHN

W. BROWN

PRINTED

AT

THE

UNIVERSITY

OF THE

STATE

OF NEW YORK

ALBANY:

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STATE

OF NEW YORK

ALBANY:

1898

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14. See: Birth Cert. et

12933

11767

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco d. STREET ADDRESS X Aquasco e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Wallace			4. DATE OF DEATH Month Day Year Oct 27 1959				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1959	9. AGE (In years last birthday) yrs. 14	IF UNDER 1 YEAR Months Days Hours Min. 14 8 45		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland, Pri. Geo. Co.			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Jeremiah Joshua Wallace				
14. MOTHER'S MAIDEN NAME Virginia Lee Douglas			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. Mother			17. INFORMANT Address Mother				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) Atelctasis Prematurity					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oct. 13, 1959, to Oct. 27, 1959			
20f. (City or town) 11:45 AM		20g. (County) 10/28/59		20h. (State) 10/28/59			
21. I certify that I attended the deceased from Oct. 13, 1959 to Oct. 27, 1959 that I last saw the deceased alive on Oct. 27, 1959 , and that death occurred at 11:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Julius C. Rubin		ADDRESS (Street, city or town, state) 5301 Hamilton St Hyattsville					
PHYSICIAN'S NAME (Type) Dr. John Perkins		DATE SIGNED 10/28/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/59		22c. NAME OF CEMETERY OR CREMATORY John Wesley			
22d. LOCATION (City, town, or county) Aquasco		22e. (State) MD.		22f. REGISTRAR'S SIGNATURE George H. Nelson			
22g. REGISTRAR'S SIGNATURE George H. Nelson		22h. ADDRESS Aquasco		22i. DATE NOV 12 59			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11/10/77

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11768 Items 3 & 8, Film G-251 11/4/59.cac.
CERTIFICATE OF DEATH

11771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly Manor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 6405 Kilmer St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle Earl Last Walters				4. DATE OF DEATH Month Oct. Day 17 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/159 2/20/59		9. AGE (In years last birthday) - yrs.	IF UNDER 1 YEAR Months 7 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Lawrence E. Walters				14. MOTHER'S MAIDEN NAME Dorothy Ann Philips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Lawrence E. Father Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500 X DUE TO Terminal aspiration of gastric contents into tracheobronchial tree Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Acute broncho pneumonia DUE TO 1 day (c) Acute purulent bronchitis DUE TO 3 days							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-15 , 19 59 , to 10-17 , 19 59 , that I last saw the deceased alive on 10-17 , 19 59 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Barry Rosenberg M.D.				ADDRESS (Street, city or town, state) 5702 Annapolis Rd. Bladensburg, Md. DATE SIGNED 10-17-59			
PHYSICIAN'S NAME (Type) Barry Rosenberg.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077243XV7

CERTIFICATE OF DEATH

11782

11781

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

11772

11798

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNKIRK</u> <u>04X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4022 PARKWOOD ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TILLIE</u> Middle <u>MAE</u> Last <u>WALTON</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS. Months <u>2</u> Days <u>10</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT BRADY</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CHARLES WALTON</u>		18. ADDRESS <u>4022 Parkwood St. Cottage City md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CARCINOMA</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 29</u> , 19 <u>59</u> , to <u>OCT 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT 31</u> , 19 <u>59</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Cmeal</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>10/31/59</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT CMEAL</u>		<u>MT RAINIER MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-3-59</u>	<u>Mt Harmony</u>	<u>Mt Dwains Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible text on a death certificate form, likely containing fields for name, date of birth, date of death, and cause of death.]

11769

CERTIFICATE OF DEATH

11773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 11 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale d. STREET ADDRESS 7009 23rd. Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Medford L Webb			4. DATE OF DEATH Month Day Year Oct. 8 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-85	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY R R Association		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME Marion Webb		
14. MOTHER'S MAIDEN NAME Roberta Vernon			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. none			INFORMANT Roberta V. Miller Address Lewisdale, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 Acute cardiac failure DUE TO (b) Mitral insufficiency Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Subacute bacterial endocarditis, healed DUE TO (c) 14 years					INTERVAL BETWEEN ONSET AND DEATH 14 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville, Md.	
21. I certify that I attended the deceased from Jan 1 , 1936, to Oct 8 , 1959, that I last saw the deceased alive on Oct. 8 , 1959, and that death occurred at 12:50P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE A Deitz		ADDRESS (Street, city or town, state) Hyattsville, Maryland.			
PHYSICIAN'S NAME (Type) A Deitz		DATE SIGNED 10-10-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/59		22c. NAME OF CEMETERY OR CREMATORY George Washington	
22d. LOCATION (City, town, or county) Hyattsville, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR OCT 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass					

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Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11774

11770

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			d. STREET ADDRESS 5020 Quebec Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hazel Middle M. Last Weber			4. DATE OF DEATH Month Oct. Day 11 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1902		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Edward Mc Carthy			12. CITIZEN OF WHAT COUNTRY? U S A		
14. MOTHER'S MAIDEN NAME Julia Rogers			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 216 22 0217			INFORMANT Address Roger L Weber College Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X DUE TO Multiple pulmonary infarctions Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Arteriosclerosis of coronary arteries 2 Ectasia of skin and adrenals					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Oct 10, 1959, to Oct 11, 1959, that I last saw the deceased alive on Oct 11, 1959, and that death occurred at 1:15 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. W.L. Etienne		M.D. 4715 Bayview Rd College Park, Md		DATE SIGNED 10/11/59	
PHYSICIAN'S NAME (Type) Dr. W.L. Etienne					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	
22d. LOCATION (City, town, or county) Washington		(State) D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE OCT 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur P. Krause					

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 3 BOX 780</u>				d. STREET ADDRESS <u>RT 3 BOX 780</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>THORNLEY ARMSTRONG WELLS</u>				4. DATE OF DEATH Month Day Year <u>Oct. 12 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 22, 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDENER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. ELIZ. HOSP. WASH. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>DAVID HICKMAN WELLS</u>		14. MOTHER'S MAIDEN NAME <u>ADA ROSS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		(If yes, give war or dates of service) <u>1902-1907</u>		16. SOCIAL SECURITY NO. <u>220-40-7354</u>		17. INFORMANT Address <u>RT 3 BOX 780 CLINTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>107 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LARGE HIATAL (ESOPHAGEAL) HERNIA - THORACIC AORTIC ANEURYSM</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>Present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 6th</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>BRANCH AVE. CLINTON MD</u>			
DATE SIGNED <u>10/12/59</u>							
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D.</u>		ADDRESS <u>BRANCH AVE. CLINTON, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros. Funeral Home</u>				ADDRESS <u>1661-Good Hope Rd SE WASH DC</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11800

CERTIFICATE OF DEATH

11776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Friendly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1931 H ST. N.E.</u>			
c. LENGTH OF STAY IN b. <u>9/13/59</u>				d. STREET ADDRESS <u>1931 H ST. N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8320 Old Fort Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Carter</u> Last <u>West</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Calpepper, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Carter</u>				14. MOTHER'S MARDEN NAME <u>Annie Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Francis Montall West</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arterio-Sclerosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Cerebral Thrombi</u> DUE TO (c) <u>Cardiac Decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>4 yrs</u> <u>54 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 5, 1959</u> to <u>10/2, 1959</u> , that I last saw the deceased alive on <u>Sept 30, 1959</u> , and that death occurred at <u>9:15p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7519 Broadview Rd S.E</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.				PHYSICIAN'S NAME (Type) <u>ANNA COYNE TODD Friendly (Pr Geo) Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Southland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Bolles</u> ADDRESS <u>4334 Hunt Pl, N.E.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton & Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11771

CERTIFICATE OF DEATH

Reg. Dist. No. 11777

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Glenn Middle White Last White				4. DATE OF DEATH Month Oct Day 22 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/01	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agric. Aide				10b. KIND OF BUSINESS OR INDUSTRY Agricultural Dept.		11. BIRTHPLACE (State or foreign country) Kansas	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Gilbert White				14. MOTHER'S MAIDEN NAME Lorinda Fair			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. Mildred Wife Address same			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 DUE TO Glio elastoma, RT Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) hemiplegia DUE TO (c) hemiplegia				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from oct 22 , 19 59 , to oct 22 , 19 59 , that I last saw the deceased alive on Oct 22 , 19 59 , and that death occurred at 7:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. C. Etienne				DATE SIGNED 10/23/59			
PHYSICIAN'S NAME (Type) W. C. ETIENNE				ADDRESS (Street, city or town, state) College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24a. REC'D BY REGISTRAR Hyattsville Md.			
24b. REGISTRAR'S SIGNATURE Arthur S. Hunt				DATE OCT 26 '59			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1971

1971

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11778

11772

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 12 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stewart James Whitney, Jr.		4. DATE OF DEATH Oct. 25, 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-47
9. AGE (In years last birthday) 11 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School boy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stewart James Whitney, Sr.		14. MOTHER'S MAIDEN NAME Beverly Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Gordon Marshall, Bladensburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Trauma, multiple and severe (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with another automobile.	
20c. TIME OF INJURY Month, Day, Year 6.11 p.m. Oct. 24, 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Springfield, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 25, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/26/59	
22c. NAME OF CEMETERY OR CREMATORY Cortland		22d. LOCATION (City, town, or county) (State) H. G.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Guscha Sons Hyattsville Md		24a. REC'D BY REGISTRAR DATE OCT 27 '59	
		24b. REGISTRAR'S SIGNATURE Edwin S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John J. [illegible]		[illegible]		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
[illegible]		[illegible]		[illegible]		[illegible]	
Date of Death		Time of Death		Place of Death		Signature of Examiner	
[illegible]		[illegible]		[illegible]		[illegible]	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of [illegible]	
[illegible]		[illegible]		[illegible]		[illegible]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11773

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11779

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stewart Middle James Last Whitney, Sr				4. DATE OF DEATH Month October Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-29	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber's Helper		10b. KIND OF BUSINESS OR INDUSTRY Plumbers		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Whitney				14. MOTHER'S MAIDEN NAME Helene Bacon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2. 110-22-0308		17. INFORMANT Beverly Whitney: same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest and abdomen, fractured pelvis, (a), stating the underlying cause lost. (c) and compound, comminuted fracture of right ankle PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with another automobile. 20c. TIME OF INJURY Month, Day, Year 6.11 10-24-59 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) Springfield, Pr. Geo. Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 25, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/26/59		22c. NAME OF CEMETERY OR CREMATORY Crittland		22d. LOCATION (City, town, or county) (State) N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche Sons Hyattsville Md				ADDRESS Hyattsville Md		24a. REC'D BY REGISTRAR Oct 27 59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

UNITED STATES DEPARTMENT OF HEALTH - BATHING MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of deceased: John J. ...</p>		<p>2. Sex: Male</p>	
<p>3. Age: ...</p>		<p>4. Date of birth: ...</p>	
<p>5. Place of birth: ...</p>		<p>6. Date of death: ...</p>	
<p>7. Cause of death: ...</p>		<p>8. Manner of death: ...</p>	
<p>9. Signature of medical examiner: ...</p>		<p>10. Signature of attending physician: ...</p>	
<p>11. Signature of coroner: ...</p>		<p>12. Signature of registrar: ...</p>	

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VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11780

11801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3															
c. LENGTH OF STAY IN 1b 1 yr. and 21 days				d. STREET ADDRESS 1011 Que St., N. W.															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last George W. Williams				4. DATE OF DEATH Month Day Year 10 13 19 59															
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/23/1877		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaner				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving				11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ned Williams				14. MOTHER'S MAIDEN NAME Mollie Roe				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) - - -				16. SOCIAL SECURITY NO. 577-14-9829				INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002x Massive pulmonary hemorrhage DUE TO Pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH 15 minutes 5 yr. 2 mo.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) the Carcinoma of prostate										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/19, 19 58, to 10/13, 19 59, that I last saw the deceased alive on 10/12, 19 59, and that death occurred at 12:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Moe Weiss, M. D. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 10/13/59 PHYSICIAN'S NAME (Type) Glenn Dale, Md.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-17-59				22b. DATE THEREOF 10-17-59				22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				22d. LOCATION (City, town, or county) (State) Washington D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE Menow & Woodford, Inc. 1622-11th St NW Brook Lyndon - A28								24a. REC'D BY REGISTRAR DATE OCT 16 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

11801

11801

11801

11802

CERTIFICATE OF DEATH

11781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale				c. LENGTH OF STAY IN 1b 7 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 6313--60th Place				d. STREET ADDRESS 6313--60th Place			
3. NAME OF DECEASED (Type or print) First MARY Middle EVERLEEN Last WILLIAMS				4. DATE OF DEATH Month October Day 19th, Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14th, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) St. Mary's County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-24-4182A		17. INFORMANT Esther J. Connolly, 6313--60th Pl. East Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardio-vascular disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 17, 1959 , to 10-19, 1959 , that I last saw the deceased alive on Oct 17, 1959 , and that death occurred at 10:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S. Fleischer				ADDRESS (Street, city or town, state) 5432 Queens Chapel Road Hyattsville, Md.		DATE SIGNED 10/20/1959	
PHYSICIAN'S NAME (Type) Ronald S. Fleischer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE OCT 21 '59		24b. REGISTRAR'S SIGNATURE Calvin S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11803

CERTIFICATE OF DEATH

11782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland Park</i>		c. LENGTH OF STAY IN 1b <i>since Feb 1957</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6508 Central Avenue</i>		d. STREET ADDRESS <i>6508 Central Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Clara</i> Middle <i>Edith</i> Last <i>Wilsor</i>		4. DATE OF DEATH Month <i>10</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-26-1877</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MISSOURI</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Thomas Chayney</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Schornhorst</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>436-464432</i>	
17. INFORMANT <i>Mrs Ruth Nelson</i>		Address <i>6508 Central Ave Maryland Park, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Arteriosclerotic heart disease</i> (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 23, 1959</i> to <i>Oct. 23, 1959</i> , that I last saw the deceased alive on <i>Oct 23, 1959</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter Duus</i>		ADDRESS (Street, city or town, state) <i>6124 Central Ave</i>	
PHYSICIAN'S NAME (Type) <i>PETER DUUS</i>		DATE SIGNED <i>10/23/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-26-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Georgel Washington</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George's Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Mattingly</i>		ADDRESS <i>131-11 Wash D.C.</i>	
24a. REC'D BY REGISTRAR <i>DATE OCT 26 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur P. Hume</i>	

11774

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 25 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle N. Last Wilson		4. DATE OF DEATH Month Oct Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/77
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Painter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John L. Wilson		14. MOTHER'S MAIDEN NAME Julia A. Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-20-1422	
INFORMANT George Wilson Brother		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, acute 332X DUE TO Encephalomalacia. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO Anteriosclerosis with thrombotic occlusion of right carotid artery. (c) Anteriosclerosis with thrombotic occlusion of			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 , 19 59 to Oct 2 , 19 59 that I last saw the deceased alive on October 2 , 19 59 , and that death occurred at 9:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irvin M. Grassgreen		ADDRESS (Street, city or town, state) IRVIN M. GRASSGREEN, M.D. DATE SIGNED	
PHYSICIAN'S NAME (Type) 3101 ARUNDEL RD, MT. RAINIER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-6-59	22c. NAME OF CEMETERY OR CREMATORY Bells Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Camp Springs M.D.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros Funeral Home		24. REC'D BY REGISTRAR 1661 Goul Hope ROSE DATE OCT 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur & Kiana	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11784

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Collage Park		c. LENGTH OF STAY IN 1b 3 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 25 5th St. Cherry Hill Motor Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KARL HEILMANN WINFELD		4. DATE OF DEATH Month Oct. Day 5 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Aug. 1896
9. AGE (In years and birthday) 63 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unkown		14. MOTHER'S MAIDEN NAME Unkown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 579-09-6546	
17. INFORMANT Marie G. Winfeld		Address (Wife) Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/59	
22c. NAME OF CEMETERY OR CREMATORY Wilmington Regional		22d. LOCATION (City, town, or county) (State) Wilmington, DE	
23. FUNERAL DIRECTOR'S SIGNATURE T. Hasekados		ADDRESS Hyattsville, Md	
C'D BY REGISTRAR 11 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11775
Reg. Dist. No. 11785

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
3. NAME OF DECEASED (Type or print) First HOMER Middle EDWIN Last WOLFF		f. STREET ADDRESS 2504 Keating Street	
4. DATE OF DEATH Month October Day 10th Year 19 59		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14th, 1901
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wolff		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes since 1942		16. SOCIAL SECURITY NO. 519-34-7112	
17. INFORMANT Ursaline M. Wolff, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 10th, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc. 816 H St. NE Wash DC		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

FOR STATE
HEALTH DEPT.

11725

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11725

NAME OF DECEASED James I. Boyd, Jr.		SEX Male		RACE White		DATE OF BIRTH August 15th, 1901		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Soldier		SERVICE U.S. Army		STATUS Single		RELIGION Catholic		EDUCATION High School	
PRESENT ADDRESS 1111 North 11th St. Baltimore, Md.		PLACE OF DEATH Home		CAUSE OF DEATH Coronary Arteriosclerosis		MANNER OF DEATH Natural		TIME OF DEATH 10:30 A.M.	
SIGNATURE OF EXAMINER [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	

11725

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF BALTIMORE, MARYLAND, FOR RECORDING IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.